

Queer Diagnoses: Parallels and Contrasts in the History of Homosexuality, Gender Variance, and the *Diagnostic and Statistical Manual*

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Abstract The American Psychiatric Association (APA) is in the process of revising its *Diagnostic and Statistical Manual* (DSM), with the DSM-V having an anticipated publication date of 2012. As part of that ongoing process, in May 2008, APA announced its appointment of the Work Group on Sexual and Gender Identity Disorders (WGSIGID). The announcement generated a flurry of concerned and anxious responses in the lesbian, gay, bisexual, and transgender (LGBT) community, mostly focused on the status of the diagnostic categories of Gender Identity Disorder (GID) (for both children and adolescents and adults). Activists argued, as in the case of homosexuality in the 1970s, that it is wrong to label expressions of gender variance as symptoms of a mental disorder and that perpetuating DSM-IV-TR's GID diagnoses in the DSM-V would further stigmatize and cause harm to transgender individuals. Other advocates in the trans community expressed concern that deleting GID would lead to denying medical and surgical care for transgender adults. This review explores how criticisms of the existing GID diagnoses parallel and contrast with earlier historical events that led APA to remove homosexuality from the DSM in 1973. It begins with a brief introduction to binary formulations that lead not only to linkages of sexual orientation and gender identity, but also to scientific and clinical etiological theories that implicitly moralize about matters of sexuality and gender. Next is a review of the history of how homosexuality came to be removed from the DSM-II in 1973 and how, not long thereafter, the GID diagnoses found their way into DSM-III in 1980.

Similarities and differences in the relationships of homosexuality and gender identity to psychiatric and medical thinking are elucidated. Following a discussion of these issues, the author recommends changes in the DSM-V and some internal and public actions that the American Psychiatric Association should take.

Keywords American Psychiatric Association · DSM-V · Gender variance · Gender identity disorder · Homosexuality · Transgender

It was six men of Hindustan
To learning much inclined,
Who went to see the Elephant
(Though all of them were blind)
That each by observation
Might satisfy the mind.

The first approached the Elephant
And happening to fall
Against his broad and sturdy side
At once began to bawl:
“Bless me, it seems the Elephant
Is very like a wall”.

The second, feeling of his tusk,
Cried, “Ho! What have we here
So very round and smooth and sharp?
To me ‘tis mighty clear
This wonder of an Elephant
Is very like a spear”.

The third approached the animal,
And happening to take

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The squirming trunk within his hands,
Then boldly up and spake:
“I see,” quoth he, “the Elephant
Is very like a snake.”

The Fourth reached out an eager hand,
And felt about the knee.
“What most this wondrous beast is like
Is mighty plain,” quoth he;
“‘Tis clear enough the Elephant
Is very like a tree!”

The Fifth, who chanced to touch the ear,
Said: “E’en the blindest man
Can tell what this resembles most;
Deny the fact who can,
This marvel of an Elephant
Is very like a fan!”

The Sixth no sooner had begun
About the beast to grope,
Than, seizing on the swinging tail
That fell within his scope,
“I see,” quoth he, “the Elephant
Is very like a rope!”

And so these men of Hindustan
Disputed loud and long,
Each in his own opinion
Exceeding stiff and strong,
Though each was partly in the right
And all were in the wrong.

John Godfrey Saxe, *The Blindmen and the Elephant*
(1873)

Introduction

“We are in a new era in which diagnosis has such social and political implications that one is constantly on the front lines fighting on issues our forebears were spared.”

Robert Stoller, M.D.¹

The American Psychiatric Association (APA) is in the process of revising its *Diagnostic and Statistical Manual* (DSM), with the DSM-V having an anticipated publication date of 2012 (Kupfer, First, & Regier, 2002; Phillips, First, & Pincus, 2003). As part of that ongoing process, in May 2008, APA announced the appointment of the members of the Work Group on Sexual

and Gender Identity Disorders (WGSIGID),² one of 13 Work Groups participating in the DSM-V revision process.

Prior to the WGSIGID appointments, media interest in the DSM process had primarily focused on possible conflicts of interests of psychiatrists with financial ties to the pharmaceutical industry (Garber, 2007). However, the announcement of the WGSIGID appointments and the group’s charge generated a flurry of concerned and anxious responses in the lesbian, gay, bisexual, and transgender (LGBT) community and blogosphere, mostly focused on the status of the diagnostic categories of Gender Identity Disorder (GID) of Adolescence and Adulthood and GID of Childhood (GIDC).³ These controversies were subsequently taken up in the LGBT press (Chibbaro, 2008; Osborne, 2008) and, shortly afterwards, the mainstream media (Carey, 2008) and professional newsletters (Melby, 2009) began reporting about them as well. The issues LGBT activists raised related to GID and the DSM are summarized below:

1. As in the case of homosexuality in the 1970s, it is wrong for psychiatrists and other mental health professionals to label expressions of gender variance⁴ as symptoms of a mental disorder and perpetuating DSM-IV-TR’s GID diagnoses in the DSM-V would further stigmatize and cause harm to transgender individuals, already a highly vulnerable and stigmatized population.
2. Some members and advocates of the trans community expressed concern that deleting GID from the DSM-V would lead third party payers to deny access to care for those transgender adults already struggling with inadequate private and public sources of healthcare funding for medical and surgical care.
3. Retention of the GID diagnoses would eventually lead to putting the diagnosis of “homosexuality,” removed from the DSM-II in 1973, back into the psychiatric manual.
4. Clinical efforts with gender variant children aimed at getting them to reject their felt gender identity and to accept their natal sex were unscientific, unethical, and misguided. Activists labeled such efforts a form of “reparative therapy.”

² The 13 WGSIGID members are Kenneth J. Zucker, Ph.D. (Chair), Irving M. Binik, Ph.D., Ray Blanchard, Ph.D., Lori Brotto, Ph.D., Peggy T. Cohen-Kettenis, Ph.D., Jack Drescher, M.D., Cynthia Graham, Ph.D., Martin P. Kafka, M.D., Richard B. Krueger, M.D., Niklas Långström, M.D., Ph.D., Heino F. L. Meyer-Bahlburg, Dr. rer. nat., Friedemann Pfäfflin, M.D., and Robert Taylor Segraves, M.D., Ph.D.

³ In DSM-IV-TR, there is only one diagnosis—GID—with separate criteria sets for children vs. adolescents/adults.

⁴ Following Meyer-Bahlburg (2009), “The nomenclature in the area of gender variations continues to be in flux, in regard to both the descriptive terms used by professionals, and, even more so, the identity terms adopted by persons with GIV [Gender-Identity-Variants].” Where possible, this author will use the term “gender variance” to refer to individuals with gender atypical behavior or self presentations.

¹ Cited in Bayer (1981, p. 10).

5. Internet bloggers and petitioners widely circulated ad hominem accusations and attacks against individual members of the WGSIGD who were characterized as prejudiced against transgender individuals (i.e., transphobic).⁵ Some professionals petitioned the APA to “balance” the work group appointments with more “trans positive” members.⁶ Fears were raised that these individuals would use their position to influence the Work Group in ways that would further exacerbate stigma and prejudice against the trans community.

There is no factual basis to the rumors that APA, which issued a 2005 position statement supporting civil marriage equality for gay people,⁷ might restore homosexuality to the DSM nor have these assertions been made by anyone affiliated with APA or the DSM process (Osborne, 2008). What constitutes a reparative therapy is addressed briefly later in this review. Meyer-Bahlburg (2009), in a related DSM review, takes up the issue of how medical treatment of gender variance might be conceptualized with or without the GID diagnosis in greater detail. Also in related reports, Cohen-Kettenis and Pfäfflin (2009) and Zucker (2009) review the diagnostic criteria of the existing GID diagnoses. Although this author questions the utility of ad hominem and ad feminam attacks by activists opposed to researchers with whom they disagree, that is a discussion for another paper.⁸

The bulk of this report explores how criticisms of the existing GID diagnoses compare with earlier historical events that led APA to remove homosexuality from the DSM in 1973. The definitive chronicle of events leading up to that decision is Bayer's (1981) *Homosexuality and American Psychiatry: The Politics of Diagnosis* in which he lays out some “deep and fundamental questions” regarding the relationship between psychiatry and homosexuality that were heatedly debated four decades ago. As the added comments in brackets below indicate, today society is debating similar questions about gender as well:

⁵ For example, see <http://www.thepetitionsite.com/2/objection-to-dsm-v-committee-members-on-gender-identity-disorders>; retrieved February 9, 2009.

⁶ For example, see <http://professionals.gidreform.org/samples.html>; retrieved July 10, 2009.

⁷ Retrieved November 9, 2008 from <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/200502.aspx>.

⁸ Several years ago, members of the LGBT community protested the content of Northwestern University's J. Michael Bailey's (2003) book, *The Man Who Would Be Queen*. While there were activists who primarily criticized the author's arguments regarding transgenderism, some activists attacked Bailey's character, reputation, and family members. Dreger (2008) has summarized an account of those events. Critics of Dreger's account of those events include Bettcher (2008), Gagnon (2008), Lane (2008), Mathy (2008), McCloskey (2008), and Nichols (2008) among others. Also see *Archives of Sexual Behavior*, Volume 37(3), 2008 for a broad range of discussions of the Dreger article.

What is normal sexuality [or normal gender]? What is the role of sexuality [or the role of gender] in human existence? Do the brute requirements of species' survival compel an answer to the question of whether homosexuality [or whether gender variance] is a disorder? How should social values influence psychiatry and help to define the concept of mental illness? What is the appropriate scope of a nosology of psychiatric disorders? How should conflicts over such issues be resolved? How should the opposing principles of democracy and authority be brought to bear in such matters? (Bayer, 1981, p. 4)

As in the case of homosexuality, arguments for removal of the “trans diagnoses” include societal intolerance of difference, the human cost of diagnostic stigmatization, using the language of psychopathology to describe what some consider to be normal behaviors and feelings and, finally, inappropriately focusing psychiatric attention on individual diversity rather than opposing the social forces that oppress sexual and gender nonconformity.⁹

In consideration of the question of removal versus retention, this review begins with a brief introduction to binary formulations that lead not only to linkages of sexual orientation and gender identity, but also to scientific and clinical etiological theories that implicitly moralize about matters of sexuality and gender. Next is a review of the history of how homosexuality came to be removed from the DSM-II in 1973 and how, not long thereafter, the GID diagnoses found their way into DSM-III in 1980. Although the DSM-IV-TR diagnosis of Transvestic Fetishism also falls under the transgender umbrella—and the history of that diagnosis is worthy of similar review—this paper confines its discussion to the history and issues surrounding the GID diagnoses and their introduction to the psychiatric nomenclature in the DSM-III.¹⁰

This paper goes on to elucidate some similarities and differences in the relationships of homosexuality and gender identity to psychiatric and medical thinking. Although this paper primarily focuses on adolescent and adult GID, it briefly addresses the question of whether efforts to convert a child's gender identity (as opposed to an individual's sexual orientation) are a form of reparative therapy. This is followed by a discussion leading to this author's recommendations for changes in the DSM-V in particular as well as some internal organizational and public policy actions that should be taken by the American Psychiatric Association.

⁹ See Karasic and Drescher (2005).

¹⁰ In a classic text on the subject, Benjamin's (1966) *The Transsexual Phenomenon* takes pains to distinguish transvestitism from transsexualism. The current DSM-IV-TR diagnosis of “transvestic fetishism,” in one form or another, has been found in all editions of the DSM. It is beyond the scope of this paper to go into that history, although, as Benjamin (1966) noted, touching upon transvestitism can be helpful in clarifying one's understanding of transsexualism.

Although the author is a member of the DSM-V Work Group on Sexual and Gender Identity Disorders, this paper and its recommendations do not necessarily represent the positions of either the Work Group or of the APA. It is just the author's own perspective. The aim of this review is to further discussion of substantive issues in the debates surrounding possible removal, modification or retention of the DSM GID diagnoses.

In preparing this review, this author was unable to find any one perspective that adequately tied together the disparate threads of understanding gender. The issues involved are complex and do not lend themselves to easy solutions. The author's own efforts to fashion such a synthesis left him pondering anew the proverbial blind men inadequately describing an elephant by touching just one of its body parts. In fact, many of the authors cited in this review have put forward some element of truth, albeit a partial one. As in the case of the blind men and the elephant, the metaphors evoked by the parts offer only a partial understanding of the whole of gender variance, gender diagnoses and the social construction of gender. In acknowledgment of gender's multiplicity, this author makes no claim of having a more acute vision than others who have theorized or written about the matter. Hopefully, readers will accept this limitation and be patient as this review takes them through the subject's complexity.

Gender Binaries, Sexual Orientation, and Gender Variance

It is not altogether surprising that questions about the proper place of gender variance in a psychiatric manual would resemble those regarding the placement of sexual orientation as well. "Both historically and cross-culturally, transgender people have been the most visible minority among people involved in same-sex sexual practices. As such, transgendered [sic]¹¹ people have been emblematic of homosexuality in the minds of most people" (Devor, 2002, p. 5). In addition, "atypical gender behavior" is not an infrequent finding in the histories of gay men and women (Bell, Weinberg, & Hammersmith, 1981; Mathy & Drescher, 2009).

Many cultures routinely conflate homosexuality with transgender identities because they rely upon several beliefs that use conventional heterosexuality and cisgender¹² identities as a

frame of reference. Once regarded as synonymous, it is only relatively recently that *sexual orientation* (defined as an individual's erotic response tendency or sexual attractions) and *gender identity* (defined as one's sense of oneself as being either male or female) have been regarded as separate categories.

History offers many examples of this conflation. For example, in the mid-19th century, Ulrichs (1994) hypothesized that some men were born with a woman's spirit trapped in their bodies. He believed these men constituted a *third sex* and named them *urnings*.¹³ While historians of homosexuality unremarkably and routinely seem to regard Ulrichs' urnings as homosexual men (Bullough, 1979; Chauncey, 1994; Greenberg, 1988), a female spirit in a male body bears a narrative kinship with 20th century theories of transsexualism. Like many theories about homosexuality and transgenderism, Ulrichs drew upon longstanding *gender beliefs*, employing implicit cultural ideas about the "essential" qualities of men and women (Drescher, 1998a, 2007; Drescher & Byne, 2009).

People express gender beliefs, their own and those of the culture in which they live, in everyday language as they either indirectly or explicitly accept and assign gendered meanings to what they and others do, think, and feel. Gender beliefs touch upon almost every aspect of daily life, including such mundane concerns as the kind of shoes men should wear or "deeper" questions of masculinity such as whether men should openly cry. Gender beliefs are embedded in questions about the kind of career a woman should pursue and, at another level of discourse, what it would mean if a professional woman were to forego rearing children or pursue her career more aggressively than a man. "Real men" and "real girls" are powerful cultural myths with which everyone must contend.

Gender beliefs draw upon *gender binaries* that usually refer to a most ancient one, that of male/female, but can also include the 19th century binary of homosexuality/heterosexuality and, perhaps in the future, the emerging 21st century binary of transgender/cisgender. Furthermore, these binaries are not confined to popular usage. Many scientific studies of homosexuality contain implicit (and often explicit) binary gender beliefs as well. For example, the intersex hypothesis of homosexuality (Byne, 1995; Drescher & Byne, 2009) maintains that the brains of homosexual individuals exhibit characteristics that would be considered more typical of the other sex. The essentialist gender belief implicit in intersex hypotheses is that an attraction to women is a masculine trait, which in the case of Freud (1920) led to his theorizing about lesbians as having a masculine psychology, while biological researchers have presumed that gay men have brains that

¹¹ The use of "transgendered" as an adjective has begun to fall out of favor and has been replaced by "transgender," as in "transgender people."

¹² Historically, the term "homosexual" preceded and necessitated the creation of the term "heterosexual"; the latter term emerged as a more specific signifier of what people used to think of as "normal." Similarly, members of the transgender community have coined the term "cisgender" to describe those whose psychological gender is concordant with their anatomical sex and who usually think of their gender identity as just "normal." "The word has its origin in the Latin-derived prefix *cis*, meaning 'on the same side' as in the *cis-trans* distinction in chemistry. In this case, 'cis' refers to the unity of a gender identity with a gender role"

Footnote 12 continued

(<http://en.wikipedia.org/wiki/Cisgender>). Some trans writers (Serano, 2007) prefer cissexual rather than cisgender.

¹³ Ulrichs defined a woman who we would today call a lesbian as *urn-ingen*, a man's spirit trapped in the body of a woman.

more closely resemble those of women (LeVay, 1991) or are recipients of extra fragments of their mothers' X (female) chromosomes (Hamer & Copeland, 1994).¹⁴

Gender beliefs usually only allow for the existence of two sexes.¹⁵ To maintain this gender binary, most cultures traditionally insisted that every individual be assigned to the category of either man or woman at birth and that individuals conform to the category to which they have been assigned thereafter (Drescher, 2007). The categories of "man" and "woman" are considered to be mutually exclusive. Iran, in contrast to Western beliefs and practices, offers a dramatically startling example of how a contemporary society equipped with sufficient modern technology can reinforce its own binary perspectives. While homosexuality is illegal there, it is estimated that about 150,000 transsexuals live in Iran, which hosts more sex-reassignment surgery (SRS) than any nation besides Thailand:

Explaining the apparent paradox, one Muslim cleric says that while homosexuality is explicitly outlawed in the Qur'an, sex-change operations are not. They are no more an affront to God's will than, for example, turning wheat into flour and flour into bread. So while homosexuality is punishable by death, sex-change operations are presented as an acceptable alternative—as a way to live within a set of strict gender binaries, as a way to, well, live like others. The tragic aspect comes through in discussions with patients and their reluctant parents in the waiting room of Tehran's pre-eminent sex-change surgeon, Dr. Bahram Mir Jalali, where it becomes clear that some feel pressured, not free, to become transsexuals. Asked if he would be preparing for surgery were he living outside Iran, one young man says, "No. I wouldn't do it. I wouldn't touch God's work." (Ellison, 2008)

Rigid gender beliefs often flourish in fundamentalist, religious communities where any information or alternative explanations that might challenge implicit and explicit assumptions are unwelcome. Iran's implementation of coercive SRS to prevent some of its gay citizens from practicing homosexuality is an extreme application of a culture's binary gender beliefs. Yet this cultural need to maintain gender binaries can also be found in the West where, since the last half of the 20th

century, intersex infants,¹⁶ even in the absence of medical necessity, have been routinely subjected to surgery for the purposes of "confirming" an earlier assignment to either male or female genders (Colapinto, 2000; Diamond & Sigmundson, 1997; Dreger, 1998, 1999; Fausto-Sterling, 2000; Kessler, 1998; Money, Hampson, & Hampson, 1955a, 1955b, 1957).

As the case of Iran illustrates, it is common when entering the realms of gender and sexuality to encounter another form of binary thinking: "morality tales" about whether certain kinds of thoughts, feelings, or behaviors are "good or bad" or, in some cases, whether they are "good or evil" (Drescher, 1998a, 2002a). The good/bad binary is not confined to religion alone as the language of morality is inevitably found, for example, in theories about the "causes" of homosexuality. For in the absence of certitude about homosexuality's "etiology," binary gender beliefs and their associated moral underpinnings frequently play a role in theories about the causes and/or meanings of homosexuality. When one recognizes the narrative forms of these theories, some of the moral judgments and beliefs embedded in each of them become clearer.

Homosexuality as Psychiatric Diagnosis

Nowhere are the moral implications of etiological theories more apparent than in the modern history of homosexuality's status as a psychiatric diagnosis. As noted elsewhere (Drescher, 1998a, 2002a), it is possible to formulate a descriptive, empirical typology of etiological theories of homosexuality¹⁷ in which they generally fall into three broad categories: *normal variation, pathology, and immaturity*.¹⁸

1. *Theories of normal variation* treat homosexuality as a phenomenon that occurs naturally. Such theories typically regard homosexual individuals as born different, but it is a natural difference, like left-handedness. The contemporary cultural belief that people are "born gay"

¹⁴ "But every once in a while... the X and Y chromosomes get jumbled up, and this little strip of DNA from a Y chromosome is 'mistakenly' passed to a daughter (or a bit of the X goes to a son). That means boys are getting a tiny bit of 'female' chromosome and girls are getting a bit of a 'male' chromosome. This raised the intriguing possibility that a genetic crossover between the male and female sex chromosomes is related to the behavioral 'crossover' between heterosexuality and homosexuality" (Hamer & Copeland, 1994, p. 128).

¹⁵ There are exceptions, as in Plato's *Symposium* and some Native American cultures (Williams, 1986). Also see Fausto-Sterling (1992, 1993, 2000) for a scientist's thoughtful criticisms of gender binaries.

¹⁶ Historically referred to as "hermaphroditism" and later as "intersex," the recent term "disorders of sex development" (DSD), like "gender identity disorder," has also divided intersex activists between those who see this medical terminology as stigmatizing and those who see it as necessary for providing informed treatment.

¹⁷ The exact "causes" of heterosexuality are also unknown, but as a dominant cultural narrative regarded as "normal," heterosexuality rarely requires explanation. Yet as Freud (1905) noted, "from the point of view of psycho-analysis the exclusive sexual interest felt by men for women is also a problem that needs elucidating and is not a self-evident fact based upon an attraction that is ultimately of a chemical nature (pp. 145–146n).

¹⁸ Among the key words in the morality tales embedded in etiological theories are "social benefit" and "social harm," "good and evil," "health and illness," "adaptive and maladaptive," "holy and sinful," or "mature and childish."

is a normal variation theory.¹⁹ As these theories equate the normal with the natural, they define homosexuality as good (or, at baseline, neutral). Such theories see no place for homosexuality in a psychiatric diagnostic manual.

2. *Theories of pathology* regard adult homosexuality as a disease, a condition that deviates from “normal,” heterosexual development. Atypical gender behavior or feelings are symptoms of a “disease” to which mental health professionals need to attend. These theories hold that some internal defect or external pathogenic agent causes homosexuality and that such events can occur pre- or postnatally (intrauterine hormonal exposure, excessive mothering, inadequate or hostile fathering, sexual abuse). Theories of pathology tend to view homosexuality as either bad or as a sign of a defect and some of these theorists are quite open about their belief that homosexuality is evil.²⁰
3. *Theories of immaturity* regard expressions of homosexual feelings or behavior at a young age as a normal step toward adult heterosexuality. Ideally, homosexuality is a passing phase that one outgrows. However, as a “developmental arrest,” adult homosexuality is equated with stunted growth. Those who hold these theories tend to regard immaturity as relatively benign, or at least not as “bad” compared to those theorists of pathology who have a tendency to emphasize the potentially malignant meanings of homosexuality.

Throughout history, discourse about homosexuality has been tied to cultural values. Thus, unsurprisingly, official pronouncements on the meanings of same-sex behaviors were once primarily the province of religions, many of which deemed homosexuality to be “bad.” However, as 19th century Western culture shifted power from religious to secular authority, homosexuality received increased scrutiny from, among others, the fields of law, medicine, psychiatry, sexology, and human rights activism. In 1869, Hungarian journalist Károli Mária Kertbeny first coined the terms “homosexual” and “homosexuality” in a political treatise against Paragraph 143, a Prussian law later codified in

Germany’s Paragraph 175 that criminalized male homosexual behavior (Katz, 1995). Kertbeny put forward his theory that homosexuality was inborn and unchangeable, arguments that it was a normal variation, as a counterweight against the condemnatory moralizing attitudes that led to the passage of sodomy laws.

Richard von Krafft-Ebing, a German psychiatrist, offered a theory of pathology that described homosexuality as a “degenerative” disorder. Adopting Kertbeny’s terminology, but not his normalizing beliefs, Krafft-Ebing’s (1965) *Psychopathia Sexualis* viewed unconventional sexual behaviors through the lens of 19th century Darwinian theory: all non-procreative sexual behaviors, now subject to medical scrutiny, were regarded as forms of psychopathology. In an ironic twist of the modern “born gay” theory, Krafft-Ebing believed that although one might be born with a homosexual predisposition, such inclinations should be considered a congenital disease. Krafft-Ebing was influential in disseminating among the medical and scientific communities both the term “homosexual” as well as its author’s view of homosexuality as a psychiatric disorder.²¹ *Psychopathia Sexualis* would presage many of the pathologizing assumptions regarding human sexuality in psychiatric diagnostic manuals of the mid-20th century.

In contrast to Krafft-Ebing, Havelock Ellis (1905), a British sexologist, considered homosexuality a normal variation of sexual expression. A normative view was also the position of the German homophile movement led by openly homosexual physician and sex researcher, Magnus Hirschfeld (1914), the major torchbearer in his time of Ulrich’s (1994) 19th century *third sex* theories.²² In contrast to Ellis and Hirschfeld’s theories of normal variation and Krafft-Ebing’s theory of pathology, Freud put forward a third kind of narrative, a theory of immaturity, that would also find its way into the popular imagination.

According to Freud (1905), as everyone is born with bisexual tendencies, expressions of homosexuality can be a normal phase of heterosexual development. His belief in innate bisexuality did not allow for the possible existence of Hirschfeld’s third sex: “Psychoanalytic research is most decidedly opposed to any attempt at separating off homosexuals from the rest of mankind as a group of special character” (p. 145n).²³ Further, Freud argued

¹⁹ These theories say that gay people are born different, but their differences are natural and intrinsic to who they are. Today, left-handedness is an apt analogy, as its presence in a minority of people is not defined as illness, although being left-handed may have disadvantages. Yet, in the past, being left-handed did lead to social opprobrium (the word *sinister* is derived from a Latin root connoting the left side) and historically, analogous to gay men, left-handed children were often treated as if they were abnormal and cured of their antisocial habit by forcing them to write right-handed.

²⁰ The psychiatrist Edmund Bergler (1956) infamously wrote in a book for general audiences, “I have no bias against homosexuals; for me they are sick people requiring medical help... Still, though I have no bias, I would say: Homosexuals are essentially disagreeable people, regardless of their pleasant or unpleasant outward manner...[their] shell is a mixture of superciliousness, fake aggression, and whimpering. Like all psychic masochists, they are subservient when confronted with a stronger person, merciless when in power, unscrupulous about trampling on a weaker person” (pp. 28–29).

²¹ *Psychopathia Sexualis* also attracted innumerable lay readers who were intrigued, and sometimes felt recognized, to finally read about experiences analogous to their own. Such readers often submitted their own accounts to Krafft-Ebing and, partly for this reason, the volume grew larger in each subsequent edition (J. Kerr, personal communication, July 11, 2009).

²² Hirschfeld would also help some of his patients obtain early access to sex reassignment surgery (Denny, 2002).

²³ Freud’s earlier diplomatic rebuke of Hirschfeld’s theory can be compared with his more contemptuous assessment several years later: “The mystery of homosexuality is therefore by no means so simple as it is commonly depicted in popular expositions—‘a feminine mind, bound therefore to love a man, but unhappily attached to a masculine body; a masculine mind, irresistibly attracted by women, but, alas! imprisoned

that homosexuality could not be a “degenerative condition” as Krafft-Ebing maintained because, among other reasons, it was “found in people whose efficiency is unimpaired, and who are indeed distinguished by specially high intellectual development and ethical culture” (p. 139).²⁴ Instead, Freud saw expressions of adult homosexual behavior as caused by “arrested” psychosexual development.

In support of that claim, he wrote several papers attributing the homosexuality of patients and historic figures to family dynamics. For example, in *Leonardo da Vinci and a Memory of His Childhood* (Freud, 1910), he attributed the artist’s homosexuality to prolonged mothering and an absent father. In *The Psychogenesis of a Case of Homosexuality in a Woman* (Freud, 1920), he argued that his female patient, disappointed by the birth of a younger brother during the pubertal resurgence of her Oedipus complex, turned away from her father and from men in general. “She foreswore her womanhood and sought another goal for her libido... she changed into a man and took her mother in place of her father as a love object” (p. 215). Toward the end of his life, Freud (1935) wrote “Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation; it cannot be classified as an illness; we consider it to be a variation of the sexual function, produced by a certain arrest of sexual development” (p. 423).²⁵

Yet, by the early 20th century, psychiatrists mostly regarded homosexuality as pathological. After Freud’s death in 1939, many psychoanalysts of the next generation would come to echo that position as well. With a few notable exceptions, they would claim a new and improved understanding of homosexuality and then proffer psychoanalytic “cures” that had eluded their field’s founder. They based their views on the theories of Rado (1940, 1969), a Hungarian émigré to the United States whose theories had a significant impact on American psychiatric and psychoanalytic thought in the mid-twentieth century.²⁶ Rado claimed, in contrast to Freud, that there was no such thing as either innate bisexuality or normal homosexuality. Heterosexuality was the only biological norm and homosexuality a “phobic” avoidance of the other sex caused by inadequate parenting.

Freud had pessimistically written in a 1920 case report, “In general, to undertake to convert a fully developed homo-

sexual into a heterosexual does not offer much more prospect of success than the reverse, except that for good practical reasons the latter is never attempted” (p. 151). In contrast, the next generation of analysts viewed efforts to cure homosexuality as akin to treating other forms of unconscious anxiety. Although retaining elements of Freud’s immaturity narrative, focusing on presumed preoedipal “causes” of homosexuality (Lewes, 1988), mid-20th century analysts regarded the “homosexual’s” development arrest less benignly than did Freud. Their pathologizing theories provided a rationale for claims of “cure.” However, despite their therapeutic optimism, most of their efforts appeared to have been unsuccessful. In a rare, controlled analytic study, Bieber et al. (1962) treated 106 homosexual men. They claimed a 27% “cure” rate with psychoanalysis, but when challenged a decade later to produce a “cured” patient, they were unable to do so (Tripp, 1987).²⁷ Although practitioners of aversion therapy in the 1960s also claimed “cures,” by the 1970s behavioral therapists admitted that few of their patients managed to stay “converted” for very long (Bancroft, 1974; Davison, 1976).

While psychiatrists, physicians, and psychologists were trying to “cure” and change homosexuality, sex researchers of the mid-20th century instead studied a wider spectrum of individuals that included non-patient populations. Psychiatrists and other clinicians inevitably drew conclusions from a biased sample of patients seeking treatment for their homosexuality or other difficulties and then wrote up findings of this self-selected group as case reports. Sexologists, on the other hand, went out and recruited large numbers of non-patient subjects for their studies.

Most prominent among those studies was the research of Kinsey and his collaborators: *Sexual Behavior in the Human Male* (Kinsey, Pomeroy, & Martin, 1948) and *Sexual Behavior in the Human Female* (Kinsey, Pomeroy, Martin, & Gebhard, 1953). The Kinsey reports surveyed thousands of people and found homosexuality to be more common in the general population than was generally believed. Kinsey’s now-famous “10%” statistic, today believed to be closer to 1–4% (Laumann, Gagnon, Michael, & Michaels, 1994),²⁸ was sharply at odds with psychiatric claims of the time that homosexuality was extremely rare in the general population. Ford and Beach’s (1951) *Patterns of Sexual Behavior*, a study of diverse cultures and of animal behaviors, confirmed Kinsey’s view that homosexuality was more common than psychiatry maintained and

Footnote 23 continued

in a feminine body.’...If [psychoanalytic] findings are taken into account, then, clearly, the supposition that nature in a freakish mood created a ‘third sex’ falls to the ground” (Freud, 1920, pp. 170–171).

²⁴ Freud (1905), in *The Three Essays*, described Krafft-Ebing’s “pathological approach to the study of inversion” as being “displaced by the anthropological. The merit for bringing about this change is due to [Ivan] Bloch, who has also laid stress on the occurrence of inversion among the civilizations of antiquity” (p. 139n).

²⁵ Freud also signed a 1930 petition calling for decriminalization of homosexuality in Germany and Austria (Abelove, 1993).

²⁶ Rado was the founder of the Columbia Center for Psychoanalytic Training and Research in New York City.

²⁷ Responding to Tripp’s challenge of Bieber’s claims of therapeutic success, rather than producing a patient, Bieber filed an ethics complaint with the American Psychological Association for impugning his “scientific honesty and credibility.” The Committee on Scientific and Professional Ethics and Misconduct found no evidence of unethical behavior (Tripp, 1987, p. 287).

²⁸ In 1903, Hirschfeld surveyed 3,000 students in a technical school and found 1.5% of the students identified as homosexual and 4.5% as bisexuals (Pfäfflin, 1997).

that it was found regularly in nature.²⁹ In the late 1950s, Hooker (1957), a psychologist, published a study that refuted psychiatric beliefs of her time, as her study failed to find more signs of psychological disturbances in a group of non-patient homosexual men compared to non-patient heterosexual controls.³⁰

American psychiatry, influenced at the time by psychoanalytic ego psychology, mostly ignored this growing body of sex research and, in the case of Kinsey, expressed extreme hostility to findings that contradicted their own theories (Lewes, 1988). This was the general state of affairs when, in 1952, APA published its first edition of the *Diagnostic and Statistical Manual* (DSM-I), listing all the conditions psychiatrists then considered to be a mental disorder. DSM-I classified “homosexuality” as a “sociopathic personality disturbance.” In DSM-II, published in 1968, homosexuality was reclassified as a “sexual deviation.” However, by 1970, the scientific research arguing for a non-pathological view of homosexuality was dramatically brought to the attention of the APA.

As Bayer (1981, 1987) has noted, factors both outside and within APA would lead to a reconceptualization of homosexuality’s place in the diagnostic manual. In addition to the research findings from outside psychiatry, there was a growing anti-psychiatry movement (Szasz, 1960) and an emerging generational changing of the guard within APA comprised of younger leaders urging the organization to greater social consciousness (Drescher, 2006a). A very few psychoanalysts like Marmor (1965) were also taking issue with psychoanalytic orthodoxy regarding homosexuality (Drescher, 2006b; Rosario, 2003). However, the most significant catalyst for diagnostic change was gay activism. In the wake of the 1969 Stonewall riots in New York City (Duberman, 1994), gay and lesbian activists, believing psychiatric theories to be a major contributor to antihomosexual social stigma, disrupted the 1970 and 1971 annual meetings of the APA.

The protests were successful in getting organized psychiatry’s attention and led to unprecedented and groundbreaking educational panels at the next two annual APA meetings. A 1971 panel, entitled “Gay is Good,” featured gay activists Frank Kameny and Barbara Gittings explaining to psychiatrists, many who were hearing this for the first time, the stigma caused by the “homosexuality” diagnosis (Gittings, 2008; Kameny, 2009; Silverstein, 2009). Kameny and Gittings returned to speak at the 1972 meeting, this time joined by John

Fryer, M.D. Fryer appeared as Dr. H Anonymous, a “homosexual psychiatrist” who, given the realistic fear of adverse professional consequences for coming out at that time, disguised his true identity from the audience and spoke of the discrimination gay psychiatrists faced in their own profession (Gittings, 2008; Scasta, 2002).

As these protests and panels took place, APA also embarked upon an internal deliberative process of considering the question of whether homosexuality should remain a psychiatric diagnosis. At a session of the 1973 APA annual meeting, participants favoring and opposing removal debated the question, “Should Homosexuality be in the APA Nomenclature?” and shortly thereafter those proceedings were published in the APA’s *American Journal of Psychiatry* (Stoller et al., 1973). The Nomenclature Committee, APA’s scientific body addressing this issue, also wrestled with the question of what constitutes a mental disorder. Spitzer (1981), who chaired a subcommittee looking into the issue, “reviewed the characteristics of the various mental disorders and concluded that, with the exception of homosexuality and perhaps some of the other ‘sexual deviations,’ they all regularly caused subjective distress or were associated with generalized impairment in social effectiveness of functioning” (p. 211). Having arrived at this novel definition of mental disorder, the Nomenclature Committee agreed that homosexuality per se was not one (Bayer, 1981; Drescher, 2003; Drescher & Merlino, 2007; Hire, 2002; Rosario, 2003; Sbordone, 2003; Spitzer, 1981; Stoller et al., 1973). Several other APA committees and deliberative bodies then reviewed their work and approved that decision. Finally, in December 1973, APA’s Board of Trustees (BOT) voted to remove homosexuality from the DSM.

Psychiatrists from the psychoanalytic community, objecting to the decision, petitioned APA to hold a referendum in which the entire membership was asked to vote either in support of or against the BOT decision (Bieber, 1987; Socarides, 1995). The decision to remove was upheld by a 58% majority of voting members.³¹ The declassification of homosexuality was accompanied by APA issuing a position statement³² (Bayer, 1981; Drescher, 2006a; Lynch, 2003) which became the first of many APA position statements supporting civil rights protections for gay people:

Whereas homosexuality in and of itself implies no impairment in judgment, stability, reliability, or vocational capabilities, therefore, be it resolved that the American Psychiatric Association deplores all public

²⁹ For more contemporary biological studies of homosexuality in animals, see Bagemihl (1999). For more contemporary anthropological views regarding homosexuality and transgenderism see Herdt (1994).

³⁰ Hooker compared 30 gay men with 30 heterosexual controls using the TAT, the Make-a-Picture-Story test (MAPS test), and the Rorschach inkblot test. Following Hooker, Siegelman (1972) compared 84 homosexual women to 113 heterosexual control and found the former “to be as well adjusted as the latter.” In a more extensive review of the literature, Riess (1980) concluded “there are no psychological test techniques which successfully separate homosexual men and women from heterosexual comparisons” (p. 308).

³¹ It should be noted that psychiatrists did *not* vote, as reported in the popular press, on whether homosexuality should remain in the diagnostic manual. What APA members voted on was to either “favor” or “oppose” the APA Board of Trustees decision and, by extension, the scientific process they had set up to make the determination (Bayer, 1981, p. 148).

³² The statement was largely based on language formulated by Richard Pillard and Lawrence Hartmann and their pioneering work on this issue within the Northern New England Psychiatric Society (Bayer, 1981).

and private discrimination against homosexuals in such areas as employment, housing, public accommodations, and licensing, and declares that no burden of proof of such judgment, capacity, or reliability shall be placed on homosexuals greater than that imposed on any other persons. Further, the APA supports and urges the enactment of civil rights legislation at local, state, and federal levels that would insure homosexual citizens the same protections now guaranteed to others. Further, the APA supports and urges the repeal of all legislation making criminal offenses of sexual acts performed by consenting adults in private.³³

Thus ended the American classification of homosexuality per se as an illness. Within two years, other major mental health professional organizations, including the American Psychological Association, the National Association of Social Workers, and the Association for Advancement of Behavior Therapy, endorsed the APA decision.

This did not, however, mean that APA was endorsing a normal variant model of homosexuality:

If homosexuality per se does not meet the criteria for a psychiatric disorder, what is it? Descriptively, it is one form of sexual behavior. Our profession need not now agree on its origin, significance, and value for human happiness when we acknowledge that by itself it does not meet the requirements for a psychiatric disorder. Similarly, by no longer listing it as a psychiatric disorder we are not saying that it is “normal” or as valuable as heterosexuality....What will be the effect of carrying out such a proposal? No doubt, homosexual activist groups will claim that psychiatry has at last recognized that homosexuality is as “normal” as heterosexuality. They will be wrong. In removing homosexuality per se from the nomenclature we are only recognizing that by itself homosexuality does not meet the criteria for being considered a psychiatric disorder. We will in no way be aligning ourselves with any particular viewpoint regarding the etiology or desirability of homosexual behavior (American Psychiatric Association, 1973, pp. 2–3).

Nor did the diagnostic change immediately end psychiatry's pathologizing of some presentations of homosexuality. For in “homosexuality's” place, the DSM-II contained a new diagnosis: Sexual Orientation Disturbance (SOD).³⁴ This

diagnosis regarded homosexuality as an illness if an individual with same-sex attractions found them distressing and wanted to change (Spitzer, 1981; Stoller et al., 1973). The new diagnosis served the purpose of legitimizing the practice of sexual conversion therapies (and presumably justified insurance reimbursement for those interventions as well), even if homosexuality per se was no longer considered an illness. The new diagnosis of SOD also allowed for the unlikely possibility that a person unhappy about a heterosexual orientation could seek treatment to become gay.³⁵

In 1980, DSM-III dropped SOD and in its place substituted “Ego Dystonic Homosexuality” (EDH) (Spitzer, 1981). However, it was obvious to psychiatrists more than a decade later that the inclusion first of SOD, and later EDH, had been the result of earlier political compromises and that neither diagnosis met the definition of a disorder in the new nosology (Mass, 1990a, 1990b). Otherwise, all kinds of identity disturbances could be considered psychiatric disorders. “Should people of color unhappy about their race be considered mentally ill?” critics asked. What about short people unhappy about their height? Why not ego-dystonic masturbation (Mass, 1990a)? As a result, ego-dystonic homosexuality was removed from the next revision, DSM-III-R, in 1987 (Krajeski, 1996). In so doing, the APA implicitly accepted a normal variant view of homosexuality in a way that had not been possible 14 years earlier.

Other diagnostic systems would eventually follow suit. In 1992, the World Health Organization (WHO, 1992) removed “homosexuality” from the Tenth Edition of the International Classification of Diseases (ICD-10), replacing it with a diagnosis similar to Ego-Dystonic Homosexuality (Nakajima, 2003).

Gender Identity Disorder and the DSM

Today, expressions of gender variance or gender nonconformity are frequently subsumed by the popular term *transgender*, a term that does not appear in the DSM or any other diagnostic manual.³⁶

“Transgender” is a relatively new word. It was originally coined by Virginia Prince in the early 1970s to refer to people who lived full-time in a gender that was not the one that usually went with their genitals (Prince,

³³ Retrieved November 9, 2008 from <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/197310.aspx>.

³⁴ Prior to 1980's DSM-III, APA published a small number of copies of the DSM. When those were exhausted, another small number was published. After running out of copies of DSM-II printed before the 1973 decision, APA printed up new copies in which “homosexuality” was replaced by “sexual orientation disturbance” (R. L. Spitzer, personal communication).

³⁵ “As Frank Kameny, a ‘gay activist,’ remarked in 1973, he had no objection to the category of Sexual Orientation Disturbance since any homosexual who was distressed at being homosexual was clearly ‘crazy’ and in need of treatment by a gay counselor to get rid of societally induced homophobia” (quoted in Spitzer, 1981, p. 211).

³⁶ Also see Leli and Drescher (2004).

personal communication).³⁷ In the 1990s, the word was taken up by a variety of people who, in their own ways, transgressed usual sex and gender expectations. It has now come to have quite a broad meaning. For many people, the term transgender includes a wide range of sex, gender, and sexual expressions which may include heterosexuals, lesbians, gays, bisexuals, queers and transsexuals (Devor, 2002, p. 8).

Currah, Green, and Stryker (2008) further elaborate on the term as

... a sense of persistent identification with, and expression of, gender-coded behaviors not typically associated with one's sex at birth, and which were reducible neither to erotic gratification, nor psychopathological paraphilia, nor physiological disorder or malady. The self-applied term was meant to convey the sense that one could live non-pathologically in a social gender not typically associated with one's biological sex, as well as the sense that a single individual should be free to combine elements of different gender styles and presentations, or different sex/gender combinations. At one level, the emergence of the "transgender" category represented a hair-splitting new addition to the panoply of available minority identity labels; at another level, however, it represented a resistance to medicalization, to pathologization, and to the many mechanisms whereby the administrative state and its associated medico-legal-psychiatric institutions sought to contain and delimit the socially disruptive potentials of sex/gender non-normativity. Having an intelligible social identity is the means by which an individual body enters into a productive relationship with social power. Thus "identity politics," the struggle to articulate new categories of socially viable personhood, remains central to the consideration of individual rights in the United States, and to the pursuit of a more just social order. The emergence of "transgender" falls squarely into the identity politics tradition (p. 3).

Like homosexuality, medical scrutiny of transgenderism also began in the 19th century. As noted above, a lack of distinction between homosexuality and transgender presentations was common. Krafft-Ebing (1965) weighed in on the side of transgenderism as psychopathology, documenting both cases of gender dysphoria and of gender variant individuals born to one sex yet living as members of the other.

³⁷ Prince's original term was "transgenderal" and she coined it as an alternative to "transsexual" to describe people who lived in the non-natal gender but did not have transsexual surgery. Prince's life story and a collection of some of her academic publications can be found in Prince, Ekins, and King (2005). Prince passed away on May 2, 2009 at the age of 96.

Hirschfeld (1923) is credited with being the first person to distinguish the desires of homosexuality (to have partners of the same-sex) from those of transsexualism (to live as the other sex).³⁸ By the 1920s, physicians in Europe had begun experimenting with sex reassignment surgery (SRS).³⁹ However, the surgical construction of gender (Garber, 1993) truly seized the popular imagination when George Jorgensen went to Denmark as a natal man and returned to the U.S. in 1952 as trans woman Christine Jorgensen (Jorgensen, 1967). Amidst great public and professional controversy, the physicians who participated in Jorgensen's SRS published a report of their treatment of her in the *Journal of the American Medical Association* (Hamburger, Stürup, & Dahl-Iversen, 1953).

The publicity surrounding Jorgensen's transition, beginning with a 1952 *New York Daily News* headline: "Ex-GI Becomes Blonde Beauty," eventually led to greater popular, medical, and psychiatric awareness of a scientific concept that would eventually come to be known as *gender identity*, as well as recognition of an increasing number of people wishing to "cross over." For those who eventually would come to identify as *transsexual*, increased public discussions of *sex reassignment* and gender identity would provide them with a way to put a name to their feelings and desires.⁴⁰ As a result, a presentation of gender (Stoller, 1985) once considered exceedingly rare would gradually become more commonplace.⁴¹

Yet, at the time of Jorgensen's 1950s transformation and for the next three decades, many psychiatrists, and particularly psychoanalytic practitioners, remained critical of sex reassignment as a treatment for gender dysphoric individuals.⁴² Most psychiatric theorizing of that time conflated sexual orientation and gender identity, and many analysts were unaware

³⁸ It should be noted that there are transgender individuals who desire to live as a member of the other sex and who neither desire nor seek medical or surgical treatment to accomplish that goal.

³⁹ In 1930, Lily Elbe (born Einar Mogens Wegener), who had been living as a woman for more than a decade, underwent sex reassignment in surgery in Germany under the supervision of Hirschfeld. Ebershoff (2000) has written a novel about Elbe, soon to be released as a film. Also see Hertoft and Sørensen (1978). Hoyer's (1933) *Man Into Woman* is also a classic early account.

⁴⁰ Blanchard (2003) attributes increased social acceptance of sex reassignment to five factors: (1) high-profile, attractive trans pioneers; (2) positive clinical evidence; (3) the backing of prestigious experts and institutions; (4) sympathetic media; and (5) a favorable social climate.

⁴¹ In line with these cultural changes, in recent years a few states have enacted laws that establish "gender identity" as a protected legislative characteristic, although it remains to be defined as a "suspect category," a term for groups likely to be subject to discrimination (other suspect classifications include race, ethnicity, age, sex, and, less frequently, sexual orientation). This is a remarkably rapid cultural shift as the modern coinage of "gender identity" only emerged in the mainstream scientific community half a century ago (Stoller, 1964).

⁴² See Socarides (1969), Hertoft and Sørensen (1978), and McHugh (1992) for psychiatric views opposing sex reassignment and Chiland (2000, 2003) for a contemporary, psychoanalytic criticism of SRS.

of, indifferent to, or at times hostile towards research from non-analytic sources that did not support their own theories (Bayer, 1981; Lewes, 1988). Many physicians and psychiatrists criticized using surgery and hormones to irreversibly—and in their view incorrectly—treat people suffering from what they perceived to be either a severe neurotic or psychotic, delusional condition in need of psychotherapy and “reality testing.” Mainstream medical thinking at the time was captured in a 1960s survey of 400 physicians that included psychiatrists, urologists, gynecologists, and general medical practitioners asked to give their professional opinions about a case history of a trans individual seeking SRS.⁴³ Green (1969) summarized the findings as follows:

Eight percent [8%] of the respondents considered the transsexual “severely neurotic” and fifteen percent [15%] considered the person “psychotic.” The majority of the responding physicians were opposed to the transsexual’s request for sex reassignment even when the patient was judged nonpsychotic by a psychiatrist, had undergone two years of psychotherapy, had convinced the treating psychiatrist of the indications for surgery, and would probably commit suicide if denied sex reassignment. Physicians were opposed to the procedure because of legal, professional, and moral and/or religious reasons. In contrast to the conservatism with which granting of sex-reassignment procedures was viewed, there was a paradoxical liberalism in the approach to these patients should they already have been successful in obtaining their surgery elsewhere. Among the respondents, three quarters [75%] were willing to allow the postoperative patient to change legal papers such as a birth certificate and to marry in the new gender, and one-half [50%] would allow the person to adopt a child as a parent in the new gender. (pp. 241–242)

It was in this cultural context that the first two editions of the DSM were published. With a significant emphasis on psychoanalytic theories of normal and pathological mental functioning, the GID diagnoses or anything equivalent did not appear in either one (APA, 1952, 1968). By 1980, however, a

newly revamped DSM-III would abandon the psychodynamic theories informing the first two volumes and instead adopt a neo-Kraepelian, descriptive, symptom-based framework drawing upon contemporary research findings (Spiegel, 2005; Zucker & Spitzer, 2005). In that shift, a growing body of research on child and adult gender identity found its way into the manual. Zucker and Spitzer (2005) summarize the vicissitudes of the current gender diagnoses from DSM-III through DSM-IV-TR:

In the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; APA, 1980), there appeared for the first time two psychiatric diagnoses pertaining to gender dysphoria in children, adolescents, and adults: gender identity disorder of childhood (GIDC) and transsexualism (the latter was to be used for adolescents and adults). In the DSM-III-R (APA, 1987), a third diagnosis was added: gender identity disorder of adolescence and adulthood, nontranssexual type. In DSM-IV (APA, 1994, 2000a), this last diagnosis was eliminated (“sunsetted”), and the diagnoses of GIDC and transsexualism were collapsed into one overarching diagnosis, gender identity disorder (GID), with different criteria sets for children versus adolescents and adults. (p. 32)

The decision to place *transsexualism* in the DSM was based on the research and clinical contributions of John Money, Harry Benjamin, Robert Stoller, and Richard Green. All took issue with the prevailing psychiatric view of their time that dismissed the existence of transgender subjectivities as a unique psychological phenomenon in its own right. The pioneering activities of these men—creating gender clinics and providing medical and surgical treatment to trans individuals—ultimately led to the new diagnosis in the DSM. They also changed professional and eventually public attitudes toward sex reassignment. Their contributions are briefly summarized below.

John Money, a psychologist and sexologist, first began publishing his theories regarding gender identity development in the 1950s (Money et al., 1955a, 1955b, 1957). Based on studies of children born with intersex conditions, Money theorized that one’s sense of being male or female—what eventually came to be known as one’s gender identity—was acquired and that acquisition was primarily determined by external, environmental factors. Citing cases of gender assignment in intersex children born with ambiguous genitalia, Money believed parental attitudes have a strong effect on whether a child accepts the gender category to which it had been surgically and medically assigned. For Money, the role of the psychosocial environment was critical: “In those instances [where the child does not accept the category to which it has been assigned],... it is common to find a history in which uncertainty as to the sex of the baby at birth was transmitted to the parents and never adequately resolved [within the parents’ mind]” (Money & Ehrhardt, 1996, p. 153).

Money coined the term *gender role* (Money 1985a, 1994), which he defined as those things that a person says or does to

⁴³ “The case history in the questionnaire read as follows: Since early childhood, this 30-year-old biological male has been very effeminate in his mannerisms, interests, and daydreams. His sexual desires have always been directed toward other males. He would like to be able to dress exclusively in woman’s clothes. This person feels inwardly and insists to the world that he is a female trapped in a male body. He is convinced that he can only be happy if he is operated on to make his body look like that of a woman. Specifically, he requests the removal of both testes, his penis, and the creation of an artificial vagina (all of which can, in fact, be done surgically). He also requests that his breasts be made to appear like a woman’s, either surgically or by the use of hormones (this, too, is medically possible)” (Green, 1969, p. 236).

disclose himself or herself as having the status of boy or man, girl or woman, respectively (e.g., general mannerisms, deportment and demeanor, etc.) and regardless of the person's anatomical sex. *Gender identity* refers to one's persistent inner sense of belonging to either the male or female gender category. Money (1994) credits the latter term's coinage to Robert Stoller.⁴⁴ Gender identity can be an independent variable in relation to sexual orientation. For example, some people can be born with a male body, have a female gender identity, and, in some cases, be attracted to men (androphilic) while others may be attracted to women (gynephilic). Money came to see gender identity as the private experience of gender role and gender role as the public manifestation of gender identity: "As originally defined, gender role consists of both introspective and the extraspective manifestations of the concept. In general usage, the introspective manifestations soon became separately known as gender identity. The acronym, G-I/R, being singular, restores the unity of the concept" (Money, 1985b, p. 279; see also Money & Ehrhardt, 1996).

Money believed a person's gender identity was fixed by three years of age, and considered efforts to change a person's gender identity difficult, if not impossible, in anyone older. Pessimism about changing an adult's gender identity left only one therapeutic alternative to improve the affected individual's well-being: sex reassignment. In the mid-1960s, in the wake of Money's theoretical work and his clinical and research findings, Johns Hopkins opened the first university-affiliated, multidisciplinary gender clinic offering sex reassignment to transsexuals seeking treatment (Green & Money, 1969). More than 40 academic centers in the U.S. would later open gender clinics as well (Denny, 1992, 2002).⁴⁵

Harry Benjamin, a physician, is credited with both popularizing the term *transsexual* in its current usage and for raising awareness about trans individuals within the medical profession (Benjamin, 1966; Green, 2009a; Ihlenfeld, 2004; Person,

2008; Pfäfflin, 1997).⁴⁶ Benjamin was a pioneering maverick who offered transgender individuals hormonal treatment at a time when mainstream psychiatry and medicine regarded gender incongruent individuals as confused homosexuals, neurotics, transvestites, schizophrenic or some combination thereof (e.g., Socarides, 1969). Benjamin, who had an essentialist view of transsexualism, had little regard for his era's psychiatrists or psychoanalysts (Ihlenfeld, 2004). He "believed that the transsexual suffers from a biological disorder, that his brain was probably 'feminized' in utero. He eschews any psychological explanation" (Person, 2008, p. 272). Consistent with his essentialist view, he believed psychotherapeutic attempts to change gender identity were "futile" (Benjamin, 1966, p. 28). As an outgrowth of his interests in the developing fields of endocrinology, gerontology, and sexology in the 1920s and 1930s, Benjamin was among the first physicians to experiment with hormonal and surgical treatments for aging—he eventually pioneered the treatment of gender dysphoric individuals using sex hormones (Ihlenfeld, 2004).

According to a colleague, "By 1972, Benjamin had diagnosed, treated, and befriended at least a thousand of the ten thousand Americans known to be transsexual. In the process, he had come to be regarded not only as the discoverer but also as the patron saint of transsexuals" (Person, 2008, p. 260). Notably, he accomplished this in a private practice setting without either university or academic support. In acknowledgment of Benjamin's early advocacy for the medical treatment of transsexualism, in 1979 the newly formed Harry Benjamin International Gender Dysphoria Association (HBIGDA),⁴⁷ which would go on to develop standards of care (SOC) for treating trans individuals, was named in his honor.⁴⁸

Robert Stoller was a preeminent member of both the American psychiatric and psychoanalytic establishments of his time (Green, 2009a). Like Money, Stoller's (1968) theorizing about gender evolved from working with both intersex and transsexual patients. Stoller (1964) is credited with introducing the concept of gender identity into both the psychoanalytic literature and into the consciousness of many psychiatrists as

⁴⁴ "I trace my initial acquaintance with this new term to communication at the time with Evelyn Hooker, the psychologist now famed for her pioneering studies in Los Angeles that led to the official depathologization of homosexuality. According to a personal communication (1984) with the late Robert Stoller, there was a psychoanalytic gender identity study group at the University of California at Los Angeles (UCLA) Medical Center during this same period, the middle 1960s" (Money, 1994, p. 166). Regular attendees of that study group included Ralph Greenson, Judd Marmor, Robert Stoller, and Richard Green (R. Green, personal communication, July 6, 2009).

⁴⁵ Money, as well as his "nurture" theory of gender identity development, was attacked in Colapinto's (2000) *As Nature Made Him*. He was accused, among other things, of falsifying published data about a pair of twin boys, one of whom lost his penis at age 8 months in a botched circumcision and was later reassigned to be a girl. Money claimed the child, referred to as "John/Joan" in the case report, successfully accepted gender reassignment. In Colapinto's book, John/Joan was revealed to be David Reimer who publicly came forward to tell his story of having rejected female assignment.

⁴⁶ Hirschfeld (1923) is credited with coining the term transvestism in 1910 and transsexualism in 1923, although he did not define the latter in its current usage (Pfäfflin, 1997). Cauldwell (1949) is often credited with the first usage of the contemporary meaning of transsexualism (Hertoft & Sørensen, 1978; Pfäfflin, 1997).

⁴⁷ Founding members include Jack Berger, Richard Green, Donald Laub, Walter Meyer, Jude Patton, Charles Reynolds, Jr., Paul Walker, Alice Webb, and Leo Wollman. Retrieved from A. H. Devor's web based history, "Reed Erickson and The Erickson Educational Foundation," at <http://web.uvic.ca/~erick123/HB>, July 7, 2009.

⁴⁸ In 2006, it was proposed that HBIGDA's name be changed to the World Professional Association for Transgender Health (WPATH). That name change became official in 2009 after a membership ballot (H. F. L. Meyer-Bahlburg, personal communication, March 2009).

well.⁴⁹ However, in contrast to Benjamin's essentialist views, Stoller (1967) believed that in some cases, childhood family dynamics were responsible for "causing" adult transsexualism.⁵⁰ Stoller (1985), undoubtedly influenced by the separation-individuation theories of Mahler, Pine, and Bergman (1975), opined that GID in boys was a "developmental arrest... in which an excessively close and gratifying mother–infant symbiosis, undisturbed by father's presence, prevents a boy from adequately separating himself from his mother's female body and feminine behavior" (p. 25).

As a medical student at Johns Hopkins, Richard Green studied cross-gender behavior in children under the supervision of his mentor John Money. Green did his psychiatric training as a UCLA resident with Robert Stoller, and later developed a close relationship with Harry Benjamin (Green, 1987, 2009a). Green and Money (1969) co-edited a groundbreaking, multidisciplinary treatment textbook, *Transsexualism and Sex Reassignment*, and published two early and important scholarly works in the field of GIDC research (Green & Money, 1960, 1961). His later volume, *The "Sissy Boy Syndrome" and the Development of Homosexuality* (Green, 1987) was a prospective study that tracked into adulthood the development of 66 gender-atypical boys who stated a wish to be a girl. Seventy-five percent of the children Green studied grew up to be gay men.

Stoller and Green were among the most prominent of psychiatrists who supported the APA decision to remove homosexuality from the DSM-II (Stoller et al., 1973). They also served on the DSM-III Subcommittee on Psychosexual Disorders that recommended including transsexualism (now called GID in adolescents and adults) in the DSM-III.

During the 1960s, North American psychiatry had begun to take a look at the phenomenon of transsexualism in adults (see, for example, Green & Money, 1969; Stoller, 1968). It became apparent that psychiatrists and other mental-health professionals had become increasingly aware of the phenomenon, that is, of adult patients reporting substantial distress about their gender identity and seeking treatment for it, typically hormonal and surgical sex-reassignment. Indeed, there were enough observed cases that it was possible in the 1960s to establish the first university- and hospital-based gender identity clinics for adults. Many clinicians and researchers were writing about transsexualism, and by 1980, there was a large enough database to support its uniqueness as a clinical

entity and a great deal of empirical research that examined its phenomenology, natural history, psychologic and biologic correlates, and so forth. Thus, by the time DSM-III was in its planning phase in the mid-1970s, there were sufficient clinical data available to describe the phenomenon, to propose diagnostic criteria, and so on (Zucker & Spitzer, 2005, p. 37).

According to Zucker and Spitzer, the case for including GID of Childhood in the DSM-III was made for similar reasons:

At the same time, there also was an emerging clinical and research literature on children who expressed the desire to be of the opposite sex, leading to a similar situation, that is, there was a clear description of the phenomenology, development of diagnostic criteria, and so on (e.g., Green, 1974; Stoller, 1968, 1975). Although research on both GIDC and transsexualism likely lagged behind other psychiatric phenomena with much higher prevalence rates, expert consensus clearly concluded that there was sufficient indication of clinical usefulness and acceptability for these two disorders to be considered for the DSM-III. In this respect, the reliance on expert consensus regarding parameters that justified inclusion was probably not much different from the many other DSM diagnoses, such as borderline personality disorder or narcissistic personality disorder, that had not been subjected to more systematic field trials (Zucker & Spitzer, 2005, p. 37).

The World Health Organization (1992) followed the DSM-III's lead in 1992's ICD-10 and included the diagnoses of transsexualism and gender identity disorder of childhood.

It should be noted that while the two GID diagnoses are grouped together in DSM, treatment approaches for GIDC seem at marked variance from the treatment philosophy of GID in adolescents and adults. In the latter case, successful treatment of gender dysphoria through sexual reassignment seems relatively uncontroversial.⁵¹ However, there is much controversy about the treatment of GIDC. Until recently, in cases of GIDC in very young children, treating gender dysphoria to prevent transition in later life was felt to be a legitimate goal. Only when such efforts fail would transition be sanctioned (Wallien & Cohen-Kettenis, 2008; Zucker, 2008a, 2008b).

It is beyond the scope of this paper to review all the issues in the debates regarding appropriate treatment of gender variant children. It should be noted, however, that changing cultural attitudes about what exactly constitutes "appropriate" expressions of gender are leading some clinicians to encourage parents in helping their children transition at earlier ages (Kennedy, 2008; Rosin, 2008; Spiegel, 2008a, 2008b). Furthermore, as in the case of homosexuality in the 1970s, LGBT

⁴⁹ A search of the largest psychoanalytic data base, PEP-WEB (<http://www.pep-web.org/>), shows that the term "gender identity" only appears in the psychoanalytic literature for the first time in the 1964 Stoller paper.

⁵⁰ Stoller's hypothesis of a "blissful symbiosis" between mother and son as a "cause" of GID is disputed by Coates (1990, 1992; Coates & Wolfe, 1995), who argues for some combination of inborn, biological temperament and alternative family dynamics as factors predisposing to GID of childhood.

⁵¹ However, see Chiland (2003), Hertoft and Sørensen (1978), and McHugh (1992) for critical views of SRS.

advocacy groups have had some recent successes in changing professional opinions about GID diagnoses. For example, in November 2008, “After repeated contacts” from the Swedish Association for Sexuality Education (RFSU) and the Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights (RFSL), the Swedish National Board of Health and Welfare (Transvestitism no longer, 2008), a governmental agency made Sweden the first country to remove the GIDC diagnosis from the Swedish version of the ICD-10, citing its potential, along with five other diagnoses, of being offensive and contributing to prejudice.⁵² The Swedish diagnostic manual, however, will retain the Transsexualism diagnosis in order to continued providing sex reassignment.

Homosexuality and GID: Parallels

Many trans activists, with the support of LGB and straight allies, are calling for removal of the GID diagnoses. In many respects, these calls resemble historic arguments that led to the 1973 removal of homosexuality from the DSM-II.

The Parallel of Turning Sin into Illness

Traditionally, religion has played a strong role in codifying socially acceptable expressions of gender and sexuality. Gender beliefs about the proper roles of men and women are firmly rooted in Judeo-Christian and other traditions that regard gender role transgressions as grounds for censure and castigation—even punishment by death. Given the historical conflation of gender expression and sexual orientation, biblical prohibitions against homosexuality are, at times, framed in language that describes men as transgressing their “natural” (that is, God-given) gender roles:

- Thou shalt not lie with mankind, as with womankind: it is abomination. (Leviticus 18:22)
- If a man also lie with mankind, as he lieth with a woman, both of them have committed an abomination: they shall surely be put to death; their blood shall be upon them. (Leviticus 20:13)
- And likewise also the men, leaving the natural use of the woman, burned in their lust one toward another; men with men working that which is unseemly, and receiving in themselves that recompence of their error which was meet. (Romans 1:27)
- Know ye not that the unrighteous shall not inherit the kingdom of God? Be not deceived: neither fornicators,

nor idolaters, nor adulterers, nor effeminate, nor abusers of themselves with mankind, nor thieves, nor covetous, nor drunkards, nor revilers, nor extortioners, shall inherit the kingdom of God. (I Corinthians 6:9).⁵³

In addition to condemning sexual transgressions, some biblical passages touch upon what would today be referred to as transvestism and transsexualism. For example, Deuteronomy 22:5 explicitly forbids cross-dressing: “The apparel of a man shall not be upon a woman and a man shall not wear woman’s garments for anyone who does these is an abomination to the Lord.” In orthodox Jewish traditions, Leviticus 22:24, “And one that is bruised, or crushed, or broken, or cut in the testicles, shall ye not offer unto the Lord; and in your land shall ye not make the like,” is interpreted as a prohibition against castrating both animals and human beings and is taken to forbid sex reassignment surgery.⁵⁴

For centuries, religious views and the legal consequences of those prohibitions held sway.⁵⁵ However, accompanying the rise of Western secularism, in the mid-19th century, scientific and medical explanatory models of nature sought to supplant religious and supernatural explanations. Yet, “as ecclesiastical authority began to wane with the rise of the modern state, the religious abhorrence of homosexual practices was carried over into secular law” (Bayer, 1981, p. 17).

In the process of casting a critical, scientific eye on a range of what were then deemed to be socially unacceptable behaviors, many “sins” would eventually come to be classified as “illnesses”: demonic possession redefined as insanity, drunkenness as alcoholism, and sodomy as an illness called homosexuality. Bayer (1981) contends that this was a model “inspired by the vision of a thoroughly deterministic science of human action. It rejected the ‘pre-modern’ stress on will and the concomitant moral categories of right and wrong. Instead it sought the causes of deviance in forces beyond the control of the individual” (p. 18).

Yet, by the mid-20th century, critics of psychiatry and the medical profession would argue that psychiatric disorders merely reflected existing social attitudes and prejudices and that they were often nothing more than forms of social control.

⁵² The other five diagnoses are F64.1, Dual-role transvestism; F65.0, Fetishism; F65.1, Fetishistic transvestism; F65.6, Sadomasochism, and F65.6, Multiple disorders of sexual preference. See “Transvestism ‘no longer a disease’ in Sweden,” published November 17, 2008; retrieved from <http://www.thelocal.se/15728/20081117/>, February 15, 2009.

⁵³ Other biblical passages interpreted as prohibitions against homosexuality can be found in Genesis 19, Leviticus 18:7, Judges 19, I Kings 22:46, II Kings 23:7, and I Timothy 1:9–10.

⁵⁴ Thanks to Naomi Mark for the Biblical references as well as the information regarding their current interpretations within the orthodox Jewish community.

⁵⁵ Boswell (1980, 1994) challenges the historical view of a linear tradition of condemnation, arguing that in different historical eras the western church tolerated same-sex relationships. Boswell (1980) and Gomes (1996) point out the selective use of biblical prohibitions by religious authority figures. Gomes (1996) and Helminiak (1994) offer alternative religious interpretations of traditional religious dogma condemning homosexuality.

The most telling example of medicine's history of diagnostic excess—and one easily held up for ridicule—is *drapetomania*, a 19th century “disorder of slaves who have a tendency to run away from their owner due to an inborn propensity for wanderlust” (Schwartz, 1998, p. 357). Szasz (1960), a psychiatrist, psychoanalyst, and spokesperson for a nascent anti-psychiatry movement, declared mental illnesses to be myths, no more than metaphors for physical illness. He characterized psychiatric nomenclature as an effort by mental health practitioners to exercise control in the guise of “providing treatment” for individuals by first defining them as “patients” and then labeling their thoughts, feelings, and behaviors as “symptoms” of imaginary “diseases.” For Szasz (1965, 1974a), psychiatry's diagnosis of homosexuality was a prototypical example of social control as was the medical model of drug addiction and the concomitant criminalization of drug users.

Although few psychiatrists today would accept Szasz's line of reasoning, particularly his theory of schizophrenia (Szasz, 1974b), his arguments regarding the social context of diagnosing mental disorders are not completely without merit. For example, the first edition of the DSM (APA, 1952) explicitly and non-self consciously articulated a role for social values in making a diagnosis of the overarching category of sociopathic personality disturbances which included homosexuality: “*Individuals to be placed in this category are ill primarily in terms of society and conformity with the prevailing cultural milieu, and not only in terms of personal discomfort and relations with other individuals*” (p. 38, my emphasis).

While physicians and psychiatrists are often accused of seeking power and control, there are also altruistic reasons for turning “sinners” into “patients”: the medical model's promise of hope for treatment and cure. An ill person was not necessarily responsible for his or her “symptoms,” and, in the best of circumstances, would benefit from therapeutic compassion rather than religious judgment and condemnation.

The stigma of psychiatric illness and the paternalism of medical practitioners notwithstanding, many “homosexuals” accepted, if not embraced, the medical model as an alternative to religious and legal condemnation. While some saw in the illness model hopes for a “cure,” Bayer (1981) sees a more practical concern:

Since the threat of criminal prosecution was the immediate danger, it is not surprising that homosexuals did not attack the standard psychiatric view of sexual deviation. With professional support hard to come by, it would have been surprising if those attempting to foster legal reform had diverted energy to the attack of those who argued that homosexuality was an inappropriate target of the criminal law (pp. 67–68).

By the 1950s and 1960s, ambivalence toward the medical model would play out in the publications of the American

homophile movement⁵⁶ as its members and allies openly debated the relative social merits and costs of pathologizing homosexuality. For example, Cory⁵⁷ (1965) spoke not only for retaining the medical model but also defended the mental health professionals coming under attack from an increasingly militant homophile movement:

Once the name was Edmund Bergler [1956]; today it is Albert Ellis... I am more and more convinced that the homophile movement in the United States... will do great harm to its struggle if it gets into a head-on clash with men of science whose work it finds threatening: and that there is nothing inconsistent between acceptance of the work of psychotherapists who report success, nay cure, and the struggle for the right to participate in the joys of life for those who cannot, will not or do not undergo such change (pp. 8–9).

By the mid-1960s, Cory's approach—advocating for gay people to have access to treatment of their homosexuality and for the gay community to collaborate with psychiatrists who pathologized homosexuality—was rejected by American homophile groups. Following the 1969 Stonewall riots, the “homophile movement” evolved into “gay liberation” and repudiated the medical model of homosexuality. The rest, as they say, is history.

Undoubtedly trans individuals in 1980, seeing a psychiatric diagnosis as the key to obtaining medical and surgical treatment, did not criticize Transsexualism's inclusion in the DSM-III. However, since treatment for gender incongruent children focused on preventing adult transsexualism, and in the case of some clinicians who claimed they were preventing homosexuality and cross-dressing (Rekers, Bentler, Rosen, & Lovaas, 1977), GIDC received a much chillier reception. Some activists and academics in the field of queer theory (Mass, 1990b; Sedgwick, 1991) asserted that the new diagnosis was a ruse perpetrated by psychiatrists to prevent homosexuality in adults.⁵⁸ Zucker and Spitzer (2005) refuted that interpretation of historical events on the basis of three reasons: (1) there was no need for a veiled backdoor diagnosis to prevent homosexuality because DSM-III [still] contained the diagnosis of ego-dystonic homosexuality; (2) that EDH was itself eventually removed from the DSM-III-R because of a lack of any empirical basis to support the diagnosis; and (3) “several clinicians and scientists who argued in favor of delisting homosexuality from the DSM-II were members of

⁵⁶ The most notable organizations in this movement were the Mattachine Society for men and the Daughters of Bilitis for women. The *Mattachine Review* and DOB's *The Ladder* would publish numerous articles debating normalizing versus pathologizing models.

⁵⁷ Donald Webster Cory was the pseudonym of Edward Sagarin.

⁵⁸ To the present day, this argument continues to resurface in the writings of gay academics and clinicians (Ault & Brzuzy, 2009; Bryant, 2007; Corbett, 1996; Haldeman, 2000).

the DSM-III subcommittee on psychosexual disorders that recommended the inclusion of the GIDC diagnosis in DSM-III” (p. 35).

Why would the same experts who persuasively and successfully argued for removal of homosexuality from the DSM-II⁵⁹ advocate for including the GID diagnoses in the DSM-III? As the following history reveals, what seems paradoxical today is the result of decisions made by individuals who lived in a different time with different ideas, different social values regarding gender, and different clinical and social agendas.

In the 1970s, professional advocates of the medical model of transsexualism found themselves arguing against a common psychiatric belief that saw trans people as severely mentally disturbed. Using an alternative medical model of illness, albeit one less pathologizing than the theories of neurosis and psychosis they opposed, they expanded professional awareness and knowledge about gender identity and sex reassignment and were eventually successful in changing psychiatric and medical opinions regarding the authenticity of trans subjectivities. As a result, they created increased possibilities for anatomically dysphoric transgender individuals to obtain the treatment they needed to live their lives unnoticed and unmolested as members of the other sex. Yet ironically, partially as a result of changes they helped bring about (authenticating and, through the DSM and later the ICD-10, solidifying a medical category of individual known as the “transsexual”) and partially due to circumstances beyond their control (the closing of university-affiliated gender clinics following the publication of Meyer and Reter’s (1979) controversial follow-up study claiming SRS confers no objective advantage in terms of social rehabilitation), cultural attitudes about gender would also change, perhaps in ways these medical pioneers never envisioned.

For example, the early transsexualism medical literature gives little indication of professional encouragement to live one’s post-transition life as an openly trans person. Christine Jorgensen, who did come out as an openly trans woman, was a rare exception. Instead, early professional proponents of sex reassignment seemed more likely to endorse (at least in their published writings) postoperative assimilation, which meant living unobtrusively as a member of the other sex. Benjamin (1966), for example, in discussing the results of male-to-female sex reassignment, noted that “several factors have to be considered: the physical and mental health, the emotional state, the social status, as compared to that before the change; the attitude of the family, the position in society, and last but by no means least, the sex life, largely dependent upon the adequacy of the newly created female genitals, especially the vagina” (p. 150). For an end result “to be assessed good, the total life situation had to be successful as well as the sex life. A good integration into the world of women with acceptance

by society and by the families was essential” (p. 151, my emphasis). Similarly, the gender clinics at Johns Hopkins and other academic centers supported a treatment model of assimilation into cisgender culture. However, by the 1980s:

The closing of [most] U.S. gender clinics created a treatment vacuum which resulted in the slow development of a market economy for the treatment of transsexualism. Free from the restrictive policies of the gender programs, transsexuals began to orchestrate their own sex reassignments, choosing services and service providers in an *a la carte* fashion. Long kept out of communication with one another by privacy requirements of gender clinics and by the insistence of the clinics that to be “proper” transsexuals they must blend into society and disappear, transsexuals began communicating with one another, seeking and providing information and comparing notes... By 1985, there were a number of support groups and regional conferences which welcomed both crossdressers and transsexuals. Around 1990, transsexuals, who had been conspicuously absent from the literature, began to publish, adding their voices to those of feminist scholars... (Denny, 2002, p. 40).⁶⁰

One consequence of less medical control of postoperative living and an increased contact among individuals were newly formed trans communities that proposed a:

new [alternative] transgender model, [in which] transsexuals were not mentally ill men and women whose misery could be alleviated only by sex reassignment, but rather [they were] emotionally healthy individuals whose expression of gender was not constrained by societal expectations. Instead, the pathology was shifted from the gender-nonconformist to a society which cannot tolerate difference... Many transsexuals, however, have reinterpreted their experience in the light of the transgender model and are less likely to disappear into society after sex reassignment than was the case under the medical model (Denny, 2002, pp. 43–44).

As increasing numbers of trans individuals began to come out of their closets, the *gay liberation movement* once again evolved and expanded more broadly into advocacy for lesbian, gay, bisexual, and transgender (LGBT) civil rights. Sexual orientation and transgender identities, once conflated, and only recently separated from each other as discrete categories, now found common political cause. One historical fact supporting such a political alliance was that many of the protestors at the 1969 Stonewall riots were transgender

⁵⁹ See, for example, Green (1972), Stoller (1973), and Stoller et al. (1973).

⁶⁰ Among the 1990s authors who self-identified as trans are Feinberg (1993), Bornstein (1994), and Wilchins (1997).

(Duberman, 1994; Stryker, 2007).⁶¹ There was also a very practical reason for the embrace of trans inclusion: those who oppose gay rights “see lesbian, gay, bisexual, and queer people’s interests as being almost the same, if not identical, to those of trans people” (Devor, 2002, p. 6).⁶² Trans inclusion would accelerate in the 1990s, as many national LGB advocacy organizations amended their mission statements to include gender identity and transgender people.⁶³

It started happening in the mid-1990s, in response to the queer movement of the early 1990s, and in response to a decade of radical AIDS activism. Fighting to end the epidemic required, from a public health point of view, getting past the squabbles of homosexual identity politics left over from the 1960s, ‘70s and ‘80s. The Reaganite right wanted to label AIDS “gay-related immune deficiency” even though viruses are no respecters of identity. AIDS was not a gay disease, but convincing others of that fact required a transformation of sexual politics. It fostered political alliances between lots of different kinds of people who all shared the common goal of ending the epidemic—and sometimes precious little else (Stryker, 2007).

Because the transgender community is so much smaller than the lesbian, gay, and bisexual one, members of the former have successfully increased their cultural and political clout by aligning with the latter as an ostensibly united LGBT community. Trans advocacy today encompasses civil rights, access to care, and promoting greater tolerance of gender variance not just in trans individuals, but also in society in general (Drescher, 2002e; Wilchins, 1997).

⁶¹ Stryker (2007) further notes, “Transgender people have their own history of civil rights activism in the United States, one that is in fact older, though smaller and less consequential, than the gay civil rights movement. In 1895, a group of self-described “androgynes” in New York organized a “little club” called the Cercle Hermaphrodites, based on their self-perceived need “to unite for defense against the world’s bitter persecution.” Half a century later, at the same time some gay and lesbian people were forming the Mattachine Society and the Daughters of Bilitis, transgender people were forming the Society for Equality in Dress. When gay and lesbian people were fighting for social justice in the militant heyday of the 1960s, transgender people were conducting sit-in protests at Dewey’s lunch counter in Philadelphia, fighting in the streets with cops from hell outside Compton’s Cafeteria in San Francisco’s Tenderloin, and mixing it up at Stonewall along with lots of other folks.”

⁶² Devor made these comments in a paper based on a lecture to members of the Association of Gay and Lesbian Psychiatrists (AGLP). Following a series of discussions leading to publications in its *Journal of Gay and Lesbian Psychotherapy*, in 2001 AGLP amended its bylaws with gender identity and transgender inclusive language (see Devor, 2002; Denny, 2002; Drescher, 2002b; Seil, 2002).

⁶³ Devor (2002) cites examples of trans inclusion at the National Gay and Lesbian Task Force (NGLTF) in 1997, Parents, Families and Friends of Gays (PFLAG) in 1998, and the Human Rights Campaign (HRC) in 2001.

From Medical Illness to Civil Rights Movements

At the time of the 1973 APA decision, organized psychiatry was not yet prepared to call homosexuality a normal variant of human sexuality. However, the diagnostic revision did end organized medicine’s formal participation in the social stigmatization of homosexuality. The APA decision shifted debate about homosexuality into the moral and political realms by depriving religious, governmental, military, media, and educational institutions of medical or scientific rationalization for discrimination.

With psychiatry no longer officially participating in stigmatization, a historically unprecedented social acceptance of gay men and women gradually ensued. Whether the APA role was causal, as this author has asserted (Drescher, 2006c) or a bellwether of wider social changes, is open to debate. Nevertheless, those who accepted scientific authority on such matters gradually came to accept the APA position and a new cultural perspective emerged: (1) if homosexuality is not an illness, and (2) if one does not literally accept biblical prohibitions against homosexuality, and (3) if contemporary, secular democracy separates church and state, and (4) if openly gay people are able and prepared to function as productive citizens, then what is wrong with being gay? And if there is nothing wrong with being gay, then what moral and legal principles should the larger society endorse in helping gay people openly live their lives (Drescher, 2002c, 2006b)?

There has been ample consideration of these questions in the last four decades and consequently much has changed. In 1973, “homosexual behavior” was illegal in most of the 50 United States. The 1970s began the proliferation of local and eventually state civil rights ordinances making discrimination on the basis of sexual orientation illegal.⁶⁴ As acceptance of gay people increased, by 2003, three quarters of the states had repealed their sodomy laws. Then, on June 26, 2003, the U.S. Supreme Court made a 6-3 historic ruling in *Lawrence and Garner v Texas* to overturn the country’s remaining sodomy laws. National and state governments are increasingly addressing the rights of same-sex couples to adopt and to act as foster parents to children.

Even some religious organizations have changed their views on homosexuality. In 2005, United Church of Christ became the first mainline Christian denomination to support same-sex marriage. Major religious groups that permit same-sex unions but that do not give them the same status as marriage include the Episcopal Church, the Evangelical Lutheran Church, and Reform Judaism. Reform Judaism now trains openly gay and lesbian rabbis.

⁶⁴ A notable exception is the U.S. federal government which to date does not yet offer any protection against discrimination on the basis of either sexual orientation or gender identity. In 1990 the federal government passed the Hate Crimes Statistics Act, the first time a federal statute recognized sexual orientation (Schmalz, 1992).

Most telling in the movement for normalization has been the rapidly changing landscape of same-sex marriage. At the time of this writing, marriage equality can be found in Belgium, Canada, the Netherlands, Norway, South Africa, Spain, Sweden, and six U.S. states: Connecticut, Iowa, Maine, Massachusetts, New Hampshire and Vermont. At least five more U.S. states are expected to follow suit in the next few years. Israel now recognizes same-sex marriages performed in other countries. Similarly, while New York State and Rhode Island do not presently allow same-sex couples to marry, they recognize gay marriages performed elsewhere. Civil unions for same-sex couples in New Jersey may soon be upgraded to marriage. This progress has been significant, despite some energetic counter-movements, such as the federal Definition of Marriage Act (DOMA), with many recent U.S. state constitutional amendments, and the 2008 referendum overturning California's Proposition 8. U.S. states with domestic partnerships include California, Hawaii, Maine, Oregon, and Washington. Numerous local municipalities and corporations throughout North America, Europe, and Latin America offer some form of legal relationship rights for same-sex couples. In addition to upgrading their current civil unions law to offering full marriage equality, many national and state governments are also addressing the rights of same-sex couples to adopt and to act as foster parents to children. These events are the result of changing cultural norms and they have had a significant impact in rapidly changing cultural views on "appropriate" expressions of gender as well.

The movement for transgender civil rights has followed more slowly in the wake of the larger gay rights movement, although the pace of the latter has picked up remarkably in the last decade. In the 1970s, with rare exceptions, local municipalities offering anti-discrimination protections on the basis of sexual orientation did not include gender identity protections (National Gay & Lesbian Task Force, 2007). By the late 1990s, as trans inclusion became a focus of LGBT civil rights organizations, it was rare to find a state or municipality that did not introduce anti-discrimination protections for sexual orientation *and* gender identity at the same time.⁶⁵ In recent years, anti-discrimination protections and/or hate crime laws for gender identity have been enacted at the statewide level in California (2003), Colorado (2005), Connecticut (2004), Hawaii (2003), Illinois (2005), Iowa (2007), Maine (2005), New Jersey (2006), New Mexico (2003), Oregon (2007), Pennsylvania (2002), Vermont (2007), and Washington (2006) (National Gay & Lesbian Task Force, 2008).⁶⁶

⁶⁵ New York State is a notable exception.

⁶⁶ Relationships between the transgender and the rest of the LGB community have not always been harmonious. Wilchins (1997), for example, recounts being excluded, during the 1990s, by lesbians at the Michigan Womyn's Music Festival, a mostly lesbian organization that to this date apparently continues to exclude trans women from open participation.

Parallels in Arguments for Diagnostic Removal

These civil rights advances notwithstanding, many in the LGBT movement are critical of psychiatry's GID diagnoses. Like the gay community that argued to be taken out of an earlier diagnostic nosology, the trans community has adopted similar normalizing arguments to make the case for removal. These include:

- adopting normalizing etiological theories, such as the belief that one is born gay/trans;
- adopting a transhistorical approach that connects modern gay/trans identities to historical figures and cultures;
- using modern cross-cultural studies to show that anti-homosexual/antitrans attitudes are culture bound;
- looking to statistics regarding prevalence to refute the notion that homosexuality/transgenderism is rare;
- underscoring the difficult, if not impossible task of changing a sexual orientation/gender identity, even through psychotherapeutic means;
- adopting and insisting upon the use of normative language to replace medical terminology ("homosexuals" become gay or defiantly queer; "gender dysphoria" becomes gender dissonance; "gender reassignment surgery" becomes gender confirmation, gender affirmation surgery, genital reassignment surgery, or bottom surgery);
- labeling theories that contradict affirmative perspectives as unscientific;
- ad hominem and ad feminam attacks on professionals who either believe homosexuality/transgenderism is an illness or use pathologizing language to make sense of homosexuality/transgenderism.

Given the sensitivities involved and the civil rights issues at stake, the push for a normative view of transgenderism, as in the case of homosexuality almost four decades ago, has led to passionate and, at times polemical, calls for a reconsideration of the GID diagnoses:

Ironically, psychiatric diagnosis has also served a humanistic purpose, sometimes for the same groups that it oppresses. Psychiatric classification can initially increase public empathy for people who are seen as suffering from a "disease" and can even enable oppressed groups to be treated more humanely, but classification comes at the cost of reinforcing the belief that certain behaviors are deviant, subnormal, or pathological, and therefore less deserving of genuinely equal rights. Thus, the removal of homosexuality from the DSM was a watershed event in gay rights history and it foreshadowed the direction of the transgender rights movement today... [T]rans people have largely stopped thinking of themselves as "disordered" or suffering from a "psychiatric disease." They are not as likely to have an uncritical gratitude towards the

benevolent and sometimes not so benevolent healers who are the gatekeepers of medical services. Mental health professionals are especially problematic for those who want body modification, because they control access to surgeons and doctors who can prescribe hormones... Transactivists are recognizing that pathologizing transgenderism is, in the end, more harmful than helpful (Nichols, 2008, pp. 476–477).

Similar normalizing arguments, less polemical but no less passionate, are made by Winters (2005), who writes:

The Gender Identity Disorder diagnosis has divided the transgender community and mental health professions alike, on the premise that relief of social stigma associated with psychosexual diagnosis must inevitably be traded against access to sex reassignment procedures for those who require them. In truth, the current GID category fails transgender, and especially transitioning transsexual individuals, on both counts. Gender variant people face barriers to social legitimacy and civil rights under medical policy that terms their gender identity as mental disorder and labels ordinary gender expressions as sexual deviance. At the same time, transsexual individuals who suffer gender dysphoria, that is distress with their physical sex characteristics or their associated social roles, face obstacles to sex reassignment treatment posed by a diagnosis of *disordered* gender identity. By labeling a person's identity, which is discordant with her or his natal sex, as *disordered*, GID implies that identity and not the body is that which needs be fixed. By its title and diagnostic criteria, the diagnosis contradicts treatment goals that correct the body (p. 72).

In the tradition of Cass (1979), who created a model of gay identity formation, Devor (2004) proposed a normalizing, 14-stage model of transsexual identity formation. Like an earlier generation of gay activists who turned to scientific findings to support their movements normalizing arguments, trans writers do so as well:

There have also been studies that have examined a small, sexually dimorphic region of the brain known as the BSTc. Researchers found that the structure of the BSTc region in trans women more closely resembles that of most women, while in trans men it resembles that of most men [Garcia-Falgueras & Swaab, 2008; Kruijver et al., 2000; Zhou, Hofman, Gooren, & Swaab, 1995]. Like all brain research, such studies have certain limitations and caveats, but they do suggest that *our brains may be hardwired to expect our bodies to be female or male*, independent of our socialization or the appearance of our bodies (Serano, 2007, p. 81, italics added).⁶⁷

⁶⁷ See Herbert (2008) for a discussion of the work of Garcia-Falgueras and Swaab (2008).

Much as the gay liberation movement spent many years citing the Kinsey studies' "10%" statistic to argue that their numbers were too large to be ignored, trans activists also see higher prevalence rates as both an antidote to invisibility as well as furthering the cause of acceptance:

In this investigative report we calculate an approximate value of the lower bound of the prevalence of male-to-female (MtF) transsexualism in the United States, based on estimates of the numbers of sex reassignment surgeries performed on U.S. residents during the past four decades. We find that the prevalence of SRS is at least on the order of 1:2500, and may be twice that value. We thus find that the intrinsic prevalence of MtF transsexualism must be on the order of ~ 1:500 and may be even larger than that. We show that these results are consistent with studies of TS prevalence emerging in recent studies in other countries. Our results stand in sharp contrast to the value of prevalence (1:30,000) so oft-quoted by "expert authorities" in the U.S. psychiatric community to whom the media turns for such information. We ponder why that community might persist in quoting values of prevalence that are roughly two full orders-of-magnitude (a factor of ~ 100) too small. Finally, we discuss the challenge that our much larger and more realistic numbers present to the medical community, public health community, social welfare community and government bureaucracies (Conway, 2002).⁶⁸

Finally, in the tradition of queer theory, what constitutes "normal" gender is deconstructed from an outsider's perspective. Just as heterosexuals were asked to look at their heterosexism, transgender writers explicate cisgenderism or cissexualism to the less gender dissonant:

Perhaps the best way to describe how my subconscious sex feels to me is to say that it seems as if, on some level, my brain expects my body to be female. Indeed, there is some evidence to suggest that *our brains have an intrinsic understanding of what sex our bodies should be...* When one's subconscious and conscious sexes match, as they do for cissexuals, an appropriate gender identity may emerge rather seamlessly. For me, the tension I felt between these two disparate understandings of myself was wholly jarring... Many cissexual people seem to have a hard time accepting the idea that they too have a subconscious sex—a deep-rooted understanding of what sex their bodies should be. I suppose that when a person feels right in the sex they were born into, they are never forced to locate or

⁶⁸ In contrast, Van Kesteren, Gooren, and Megans (1996) estimate the prevalence of transsexualism as 1 in 12,000 natal males and 1 in 30,000 natal females. As in the gay of GLB populations, transgender individuals are frequently rendered invisible in population surveys (Drescher, 2009a).

question their subconscious sex, to differentiate it from their physical sex. In other words, their subconscious sex exists, but it is hidden from their view. They have a blind spot (Serano, 2007, pp. 80–87, my emphasis).

Table 1 lists some of the parallels between homosexuality and gender variance as they relate to psychiatric diagnosis.

Homosexuality and GID: Contrasts

Possibly Harmful Consequences of Removing GID

Gay activists of the mid-20th century were fighting both for civil rights and sexual liberation. Toward that end, and to keep medical practitioners from unnecessarily meddling in gay people's lives, most of them wanted out of the DSM. The same approach is undoubtedly true for transgender people who are not anatomically dysphoric and who therefore see no reason why mental health professionals should judge them in the language of psychiatric diagnosis.

Among those who do seek to transition, there are activists and supporters who wish to retain the psychiatric diagnosis as a needed step in obtaining medical treatment. Some might unfavorably be compared to Donald Webster Cory, an early homophile activist who held a distinctly minority position that gay people should cooperate with psychiatrists in order to obtain medical treatment of their homosexuality.

There are also trans activists who would prefer that psychiatry not meddle in their decision to transition and that mental health professionals should forego their currently assigned gate-keeping role of determining psychological fitness for transition. As they seek a diminished role for psychiatry, they advocate for increased access to physicians providing medical and surgical care for transition. Some suggest placing transsexualism as a “medical” rather than a “psychiatric” diagnosis of the ICD (unlike the DSM, there is no American equivalent to the non-psychiatric section of the ICD). However, it is not clear whether such an approach would be amenable to the World Health Organization committees presently charged with updating the ICD.⁶⁹

Presently, however, where either insurance or national health care systems cover these procedures, it is a psychiatric diagnosis that currently justifies “medical necessity” for such care. So while removal from the DSM led to a liberating and immediate “cure” (Drescher, 2002f) for members of the gay community, a similar approach with GID could have unintended, adverse treatment consequences, particularly for the anatomically dysphoric transgender individuals seeking or in need of medical transition.

Difficulty Finding Reconciling Language that Removes the Stigma of Diagnosis while Maintaining Access to Medical Care

As in the case of EDH, there are voices seeking a middle ground between avoiding the stigma of having a diagnosis while at the same time justifying the need for medical and surgical treatment. In an effort to resolve the contradictory moral implications between narratives of pathology and normal variation, conventional language can be stretched in a variety of ways as a balance is sought between avoiding stigma and obtaining needed services and social concessions:

It took the gay-rights movement 30 years to shift from the Stonewall riots to gay marriage; now its transgender wing, long considered the most subversive, is striving for suburban normalcy too. The change is fueled mostly by a community of parents who, like many parents of this generation, are open to letting even preschool children define their own needs. Faced with skeptical neighbors and school officials, parents at the [Trans Health] conference discussed how to use the kind of quasi-therapeutic language that, these days, inspires deference: tell the school the child has a “medical condition” or a “hormonal imbalance” that can be treated later, suggested a conference speaker, Kim Pearson; using terms like *gender-identity disorder* or *birth defect* would be going too far, she advised. The point was to take the situation out of the realm of deep pathology or mental illness, while at the same time separating it from voluntary behavior, and to put it into the idiom of garden-variety “challenge.” (Rosin, 2008)

From the perspective of clinicians, Levine and Solomon (2009) self-consciously, and somewhat defensively, try to parse out the conflict between normal variant and pathological models of transsexualism. Although they say, “Our work begins with the belief that GID is a fact of nature,” (p. 51), by which one might presume they think of transgenderism as a natural condition, they nevertheless assert:

1. In a nosological sense, GID are [sic] forms of psychopathology;
2. Gender identity disorders are typically co-morbid with other psychopathologies;
3. The promotion of civil rights for the transgendered can obscure professional perceptions of psychopathology;
4. Ethical obligations require professionals to communicate the uncertainties about the long-term outcome of gender transition and sex reassignment surgery (SRS) (p. 41).

Levine and Solomon (2009) then go on to make a spirited defense for retaining the language of psychopathology needed as a separate category of discourse required for the clinical work. Despite the obvious narrative contradictions of their

⁶⁹ The ICD is being revised for an 11th edition (ICD-11) scheduled for a 2014 release.

Table 1 Homosexuality, gender variance and psychiatric diagnosis: parallels

	Homosexuality	Gender variance
Social justice as rationale for removal	Yes	Yes
Empirical basis as rationale for removal	Yes (Sexology Research) Controversial at time of removal	Empirical data for both retention and removal are controversial
Etiological theories reflect good and bad moral judgments	Normal Variation of Human Sexual Expression <i>Homosexuality is good and natural</i> Psychopathology <i>Homosexuality is bad and the homosexual orientation needs to be fixed</i> Psychological Immaturity <i>Homosexuality is bad and gay people need to grow up</i>	Normal Variation of Human Gender Expression <i>Transgender is good and natural</i> Psychopathology <i>Transgenderism is bad and the gender discordance needs to be fixed</i> Psychological Immaturity <i>Transgenderism is bad and a form of arrested development</i>
Biblical condemnation	Genesis 19 Leviticus 18:7, 22 Leviticus 20:13 Judges 19 I Kings 22:46 II Kings 23:7 Romans 1:27 I Corinthians 6:9 I Timothy 1:9–10	Deuteronomy 22:5 Leviticus 22:24
Modern religious attitudes	Mostly condemning, with some religions and denominations more accepting	Mostly condemning, with some religions and denominations more accepting
Early normalizing theories	Ulrich's <i>Urnings</i> and <i>Urningen</i> , 1864 Kertbeny's "Homosexual," 1869 Havelock Ellis, 1905 Magnus Hirschfeld, 1914	Ulrich's <i>Urnings</i> and <i>Urningen</i> , 1864 Virginia Prince's <i>Transgenderist</i> and <i>Transgenderism</i> , 1968
Medicalization, although stigmatizing, leads to wider social recognition and acceptance of category of person	"The Homosexual" Krafft-Ebing, 1965 "The Invert" Freud, 1905 The Homosexual Neurosis Stekel, 1922 "The Pervert" Rado, 1940	"Psychopathia Transsexualis," Cauldwell, 1949 "Blissful Symbiosis" Stoller, 1964 "The Transsexual Phenomenon" Harry Benjamin, 1966 "Transsexualism" DSM-III, 1980 "GID of Adulthood & Adolescence" DSM-IV, 1994
Theories of immaturity	Freud, 1905	Stoller, 1968
Members of stigmatized group accept medical labels	Illness and immaturity preferable to sin Illness model offers hope of "cure" Immaturity model offers hope of "growth"	Illness model provides rationale for medical interventions facilitating transition
Later normalizing theories	Kinsey Reports, 1948, 1953 Ford and Beach, 1951 Evelyn Hooker, 1957 Cass, 1979	Denny, 1992 Devor, 2004 Serano, 2007
Members of stigmatized group reject medical labels	Diagnoses seen as patronizing, demeaning and perpetuating of stigma	Diagnoses seen as patronizing, demeaning and perpetuating of stigma
Diagnostic category used to justify discrimination	Immigration law, military service, marriage, adoption, inheritance and other taxes, insurance, medical benefits	Americans with Disability Act (ADA) specifically excludes transsexualism; Refusal of life and disability insurance benefits
Social consequences of removing Diagnosis from DSM	GLB individuals relieved of mental disorder label; Loss of rationalization for denying full equality in immigration, work, marriage, family law, etc.	Trans individuals who are not anatomically dysphoric relieved of mental disorder label; Loss of rationalization for denying full equality in immigration, work, marriage, family law, etc.

approach, they argue that such language should imply no moral judgments about the patients:

There are three advantages to the designation of a pattern of behavior as a disorder. The first is that professionals with a scientific background are more likely to study the origins, consequences, and treatment of disorders than other patterns. Scientific study offers the possibility of new knowledge and efficacious treatment based on evidence. The second is that third-party payment for evaluation and therapy services is linked to diagnoses. There is no insurance coverage for unofficial problems. The third is that some of the suffering attendant to these patterns can be ameliorated (pp. 43–44).

To repeat, efforts to straddle the contradictory implications of having a diagnosis (bad, disordered) while putting forth a narrative of normal variation (good, natural) can be seen as trying to foster an environment in which offering medical and surgical treatment does not imply stigma or judgment.

The Washington Psychiatric Society (2009) Task Force on Gender Identity Disorder similarly struggles to find language that “maximizes” access to medical, surgical, and mental health care while mitigating the potentially discriminatory uses of the diagnostic categories to restrict access to public accommodations. The report notes, “In the current absence of means to resolve this dilemma satisfactorily (e.g., structural reform of the health care system), we propose revisions to the diagnostic categories available to care for gender variant persons” (pp. 1–2). In their struggle to find reconciling language, they even propose what might be called a “bookkeeping” solution: that GIDC be removed from the DSM and replaced with the V-Code of Child/Adolescent Gender Variance. This diagnosis would be applicable until age 18 and presumably flag those gender variant children (and their families) who seek some form of psychological treatment. While this would reduce stigma by defining gender variance before age 18 as a subject of clinical attention rather than a psychiatric disorder, the redefinition would only exacerbate the access to care problem as third party payers rarely reimburse V-codes.

APA and LGBT Civil Rights

Following the events of 1973 and with subsequent generational changes in the organization, APA gradually became a more socially conscious group. Given psychiatry’s historical role in stigmatizing homosexuality in mind, and thanks to the efforts of a growing number of openly gay, lesbian, and bisexual psychiatrists coming out in the organization (Ashley, 2002; Barber, 2003, 2008; Hire, 2001), APA continued to expand its public positions regarding gay and lesbian civil rights. In 1990, APA issued a statement opposing “exclusion and dismissal from the armed services on the basis of sexual

orientation.”⁷⁰ In 1992, APA called on “all international health organizations, psychiatric organizations, and individual psychiatrists in other countries to urge the repeal in their own countries of legislation that penalizes homosexual acts by consenting adults in private.”⁷¹

In 1998, APA issued a statement opposing “any psychiatric treatment, such as ‘reparative’ or ‘conversion’ therapy, that is based on the assumption that homosexuality per se is a mental disorder or is based on the a priori assumption that the patient should change his or her homosexual orientation.”⁷² In 2000, APA strengthened the statement, recommending, “ethical practitioners refrain from attempts to change individuals’ sexual orientation (American Psychiatric Association, 2000b).”⁷³

Then, in 2000, following Vermont’s passage of civil unions laws, APA endorsed “the legal recognition of same-sex unions and their associated legal rights, benefits and responsibilities.”⁷⁴ In 2002, APA called for “initiatives allowing same-sex couples to adopt and co-parent children and supports all the associated legal rights, benefits, and responsibilities which arrive from such initiatives.”⁷⁵

In 2003, APA signed onto an amicus brief for the gay plaintiffs in the US Supreme Court case of *Lawrence and Garner v. Texas*. This historic Supreme Court decision abolished discriminatory US sodomy laws that criminalized homosexuality.⁷⁶

In 2005, after Massachusetts’ 2004 legalization of marriage equality, APA issued a statement supporting “the legal recognition of same-sex civil marriage with all rights, benefits and responsibilities conferred by civil marriage, and opposes restrictions to those same rights, benefits, and responsibilities.”⁷⁷

⁷⁰ Retrieved November 9, 2008 from <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/199013.aspx>.

⁷¹ Retrieved November 9, 2008 from <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/199216.aspx>.

⁷² Retrieved November 9, 2008 from <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/199820.aspx>.

⁷³ Retrieved November 9, 2008 from <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/200001.aspx>.

⁷⁴ Retrieved November 9, 2008 from <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/200003.aspx>.

⁷⁵ Retrieved November 9, 2008 from <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/200214.aspx>.

⁷⁶ *Lawrence v Texas*, retrieved November 9, 2008 from <http://www.law.cornell.edu/supct/html/02-102.ZS.html>.

⁷⁷ Retrieved November 9, 2008 from <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/200502.aspx>.

In 2006, APA created the John Fryer Award for “a public figure who has made significant contributions to LGBT mental health.” Named for the once-disguised Dr. H Anonymous’ alter ego, the award’s first recipients were Frank Kameny and Barbara Gittings, two of the gay activists who 35 years earlier brought the issue of psychiatric stigmatization of homosexuality to APA’s attention (Gittings, 2008).⁷⁸

The Caucus of Gay, Lesbian, and Bisexual Members of the American Psychiatric Association (CGLBM-APA) was established in the mid 1970s and is active within APA to this day.⁷⁹ In 1978, APA created a task force on gay and lesbian issues that in 1981 was upgraded to a standing Committee on Gay, Lesbian and Bisexual (GLB) Issues. While originally charged to focus on GLB issues, a revised charge was approved and updated in 2004 to include trans issues as well.⁸⁰ Due to a 2009 restructuring of APA governance, the Committee on GLB issues (among scores of others) was “sunsetting” and the GLB Caucus is now the de facto APA component charged with addressing LGBT issues.

In contrast to its strong affirmation of LGB civil rights after the 1973 decision to remove homosexuality from the DSM, APA has not issued position statements in support of transgender civil rights. One explanation for this disparity may be that there are hundreds of openly LGB psychiatrists advocating for organizational awareness of LGB rights, both within APA as well as in its allied organization, the Association of Gay and Lesbian Psychiatrists (AGLP). There are very few visible trans psychiatrists within either organization.

The Committee on Gay, Lesbian, and Bisexual Issues often functioned as the default clearinghouse for queries to the APA about trans issues; however, in 1997 the Committee drafted a *Committee Report: The Diagnostic Category of Gender Identity Disorder (GID)* (Committee on Gay, Lesbian, and Bisexual Issues, 1997). Its heretofore unpublished recommendations included:

- (1) That the assumptions fueling the conceptual confusions in the GID diagnosis be examined through the creation of an APA task force composed of members from APA’s Committees on Women, Abuse and Misuse of Psychiatry in the US, DSM, Gay, Lesbian and Bisexual Issues, Components of the Council on Children, Adolescents and Families, and transgendered members of the APA.
- (2) That documentation of possible misuses of the GID diagnosis must be substantiated. Misuses should be addressed, perhaps by the Ethics Committee.

- (3) A clear distinction between homosexuality and GID must be made in the next DSM.
- (4) To avoid nosologic confusion between GID categories in adults and children and to remove unfounded etiologic links between the two, we should separate the diagnosis of GID in children from GID in adults.
- (5) That a scientific dialogue be established among members of the transgender community, interested APA members, and the DSM-V Committees on GID.

The draft report appears not to have been widely distributed within APA and is not accessible via a search of APA’s website. To this author’s knowledge, no action was taken on any of the report’s recommendations. In fact, prior to the recent DSM controversies (Chibbaro, 2008; Osborne, 2008), APA’s only official public statements regarding transgender people are the DSM’s GID diagnoses and transvestic fetishism.

Further, while it is often asserted that the DSM (and ICD) diagnoses provide the only pathways to insurance reimbursement for trans individuals seeking medical assistance, APA has issued no treatment guidelines for either GIDC or adult GID. This omission is in stark contrast to an increasing proliferation of APA practice guidelines for other DSM diagnoses.⁸¹ In addition, the absence of a formal APA opinion about treatment of a diagnosis of its own creation has contributed to an ongoing, troubling problem: many health care insurers and other third party payers claim that SRS is an “experimental treatment,” an “elective treatment,” or “not medically necessary” and therefore not reimbursable or covered under most insurance plans and treatment is not always accessible to wards of governmental agencies, such as foster care and prison systems. In other words, the presence of the GID diagnosis in the DSM is not serving its intended purpose of creating greater access to care—one of the major arguments for diagnostic retention.

In an effort to address this longstanding omission, APA’s Board of Trustees voted in December 2007 to create a special Task Force to review the scientific and clinical literature on the treatment of GID. That Task Force was convened in 2008 and is presently reviewing the published literature on treatment issues.

Table 2 lists some of the contrasts between homosexuality and gender variance as they relate to psychiatric diagnosis.

⁷⁸ Subsequent winners of the Fryer award were Lawrence Hartmann, MD (2007), Richard C. Pillard, MD (2008), and San Francisco Mayor Gavin Newsome (2009).

⁷⁹ See <http://www.aglp.org/pages/chistory.html>.

⁸⁰ This author chaired the APA Committee on GLB Issues from 2000 to 2006 and fielded numerous questions from journalists and advocacy groups regarding APA positions on gender identity and transsexualism.

⁸¹ APA has issued Practice Guidelines for Acute Stress Disorder and Posttraumatic Stress Disorder, Alzheimer’s Disease and Other Dementias of Late Life, Borderline Personality Disorder, Bipolar Disorder, Delirium, Eating Disorders, HIV/AIDS, Major Depressive Disorder, Panic Disorder, Psychiatric Evaluation of Adults, Schizophrenia, Substance Use Disorders and Suicide. The American Psychological Association has recently issued a report recommending clinical approaches to gender dysphoric and gender variant patients (APA Task Force on Gender Identity and Gender Variance, 2008).

Table 2 Homosexuality, gender variance and psychiatric diagnosis: contrasts

	Homosexuality	Gender variance
Year placed in DSM	1952 (DSM-I)	1980 (DSM-III)
Current status as DSM Mental Disorder	No	GID GIDC Transvestic fetishism
Year removed from DSM	1973 Homosexuality removed from DSM-II and replaced by Sexual Orientation Disturbance 1980 Sexual Orientation Disturbance replaced by Ego Dystonic Homosexuality in DSM-III 1987 Ego Dystonic Homosexuality removed in newly revised DSM-III-R	N.A.
Scientific rationale for diagnostic category	Alternative model to prevailing religious views of homosexuality as sin or immorality	Alternative to prevailing psychiatric model of transsexualism as a symptom of psychosis or severe neurosis
Medical rationale for diagnostic category	Diagnosis justified psychiatric interventions aimed at changing homosexual orientations	Diagnosis justified providing medical and surgical treatment to enable transition
Presence of diagnosis in DSM has increased access to care	N.A.	Limited success in US where most third party payers do not cover treatment of the diagnosis. Greater success in other countries (using ICD) where national health care systems pay for treatment
The role of activism	Catalyzed 1970–1973 APA debates that eventually led to 1973 removal of homosexuality from DSM-II	Impact on status of GID diagnoses in DSM-V uncertain
Medical consequences of Removing Diagnosis from DSM	No immediate medical consequences—DSM text has remained mostly silent on sexual orientation as an associated factor (like race, age, ethnicity) in psychiatric disorders	Possible loss of access to care—where third party payment is available, it depends upon meeting current diagnostic criteria
Reconciling language to remove stigma of diagnosis while maintaining access to medical care	N.A.	Difficult to reconcile
Chronological relationship between place in DSM and civil rights advances	Civil rights advances gradually followed removal from DSM	Civil rights advances have proceeded despite inclusion in DSM
APA Practice Guidelines offering professional guidance regarding treatment	N.A.	None, despite inclusion in DSM for almost 30 years; Board of Trustees authorized creation of Task Force to explore this issue in 2007
APA position statements in support of civil rights	Opposes discrimination in work and housing (1974) Opposes discrimination in the US Armed Forces (1990) Calls for repeal of antihomosexual laws in other countries (1994) Opposes conversion therapies (1998, 2000) Supports second parent adoptions (2002) Supports civil marriage equality (2005)	None
APA components charged with advocating for minority groups	Caucus of Gay, Lesbian, and Bisexual Members (CGLBM-APA) Committee on Gay, Lesbian and Bisexual Issues (1981–2009)	None

Are Clinical Interventions with Gender Variant Children Reparative Therapy?⁸²

This author has written and edited numerous reviews and criticisms of so-called reparative therapies and other sexual orientation conversion efforts (Drescher, 1997, 1998a, 1998b, 1998c; 2001, 2002c, 2002d; Drescher & Zucker, 2006). However, this author's understanding of that literature had not previously understood the term as applying to the prevention of adult transsexualism in gender variant children.

Historically, there have been a range of theoretical and clinical approaches to changing homosexuality, i.e., psychoanalysis, aversion therapy, behavioral techniques, etc. The American Psychological Association's Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009) reviews all these approaches and classifies them with the overarching term "Sexual Orientation Change Efforts" (SOCE).⁸³

For purposes of conciseness, the term "reparative therapy" is a subset of SOCE and primarily associated with the work of Nicolosi (1991). A fusion of religion and older psychoanalytic theories of homosexuality, reparative therapy interventions for "treating" male homosexuality are based on a developmental theory that claims a "failure to fully gender identify [with male figures leads to a] deficit in sense of personal power. Homosexuality is understood to represent the drive to repair the original gender-identity injury" (p. xvi). Homosexuality, in this model, is analogized to vitamin deficiency diseases, in which the missing ingredients that "make people gay" are "good enough relationships" with one's same-sex parent. Reparative therapists claim their interventions repair or "heal" these putative "deficits."

Nicolosi's reparative therapy has roots, beginning in the 1970s, in efforts to provide pastoral care to "homosexuals" despite long-standing Christian beliefs about the special sinfulness of same-sex thoughts, attractions, and behaviors (Erzen, 2006; Harvey, 1987; Moberly, 1983a, 1983b). Reparative theorists are quite straightforward in their belief that homosexuality is a mental disorder and a social problem. For example, Moberly (1983a) asserts, "Traditionally, the Christian faith has regarded homosexual activity as inappropriate, as contrary to the will and purposes of God for mankind...it seems to the present writer that one may not avoid the conclusion that homosexual acts are always condemned and never approved. The need for reassessment is not to be found at this point" (p. 27). In a similar vein, Nicolosi (1991) sees human sexuality through a metaphysical lens that elevates heterosexuality and denigrates same-sex relationships:

Each one of us, man and woman alike, is driven by the power of romantic love. These infatuations gain their power from the unconscious drive to become a complete human being. In heterosexuals, it is the drive to bring together the male-female polarity through the longing for the other-than me. But in homosexuals, it is the attempt to fulfill a deficit in wholeness of one's original gender (p. 109).

Some significant contrasts between reparative therapists and DSM-V Workgroup members who treat gender variant children are that none of the latter practice from a religious orientation, their published works do not explicitly cite religious dogma, they do not think homosexuality is a sin or an illness, they do not think it is wrong to be gay, they do not see a gay outcome as a treatment failure, they do not call what they do reparative therapy, and they do not reference reparative therapy literature in support of their clinical approaches.⁸⁴ It may also be true that reparative therapists may cite references from DSM-V Workgroup members, but distorting the findings of mainstream researchers in support of their controversial approaches is not an uncommon practice among advocates and practitioners of conversion therapy (Drescher, 2002d, 2009b).

It appears that labeling these clinical practices as "reparative therapy" primarily rests on the analogy that trying to change an individual's gender identity (gender identity conversion efforts or GICE⁸⁵) means the same thing as trying to change an individual's sexual orientation (SOCE).

What is the source of the comparison? The earliest reference in a scholarly publication is not in a review article or study, but a letter to the editor of the *Journal of the American Academy of Child and Adolescent Psychiatry*. There, Pickstone-Taylor (2003) criticized Bradley and Zucker's (1997) report of treating gender variant children and compares their work to reparative therapy of homosexuality. However, Pickstone-Taylor's letter makes no mention of the religious or other theoretical beliefs underlying reparative therapies but instead focuses on what he sees as analogous efforts to reinforce gender conformity in adult gay patients and in gender variant children. Winters (2005, p. 77), in her critical discussion of Bradley and Zucker's work with children, cites APA and other organizations' policies against reparative therapies. However, none of those professional policy statements explicitly address the ethics or efficacy of efforts to change gender identity in children. Hill, Rozanski, Carfagnini, and Willoughby (2007, p. 61) also describe efforts to change gender variant children as "reparative therapy." While their positions may be valid, these authors do not provide any details to support the analogy. Further, at present there is no scholarly

⁸² At the request of the GID subgroup of the Workgroup on Sexual and Gender Identity Disorders, and because of expertise in the area of sexual orientation conversion efforts, this author has included this brief digression from the main issues addressed in this review.

⁸³ The author served as a member of that American Psychological Association Task Force.

⁸⁴ For example, see Zucker (2000, 2005, 2006) and Bradley and Zucker (2003).

⁸⁵ Kelley Winters (personal communication) has recently suggested the term.

literature to support the comparison. Why call them “reparative therapy?”

Certainly, the political benefits of the analogy seem undeniable. Given the small size of the transgender community, mobilizing opposition to “reparative therapy,” a perennial *bête noire* of the larger LGB community provides a useful political shorthand: trying to change trans kids is obviously just like trying to change gay adults. Yet, as politically compelling as it may be to assert that changing sexual orientation means the same thing as changing gender identity, the analogy is problematic in other situations. For example, civil rights protections based on sexual orientation do not provide civil rights protections for transgender individuals. If they did, there would be no need to seek more inclusive language protecting “gender identity” in civil rights legislation.

This author believes a more detailed and scholarly study of potential harm from GICE and how that may compare with SOCE seems worthwhile. Hopefully, this challenging work will be taken up by interested colleagues who wish to immerse themselves in both the reparative therapy literature as well as the literature on clinical interventions to change gender variant children. However, such a review is beyond the scope of this paper.

Discussion

As this review has tried to show, there are similarities and differences in the histories of diagnosing homosexuality and gender variance as mental disorders. These histories underscore the fact that many, if not all, diagnostic categories have a social context. The most extreme examples of abusive authority creating psychiatric diagnoses for purposes of exercising power and control are always jarring, as in the case of diagnosing escaped slaves in the antebellum South or “hospitalizing” political dissidents in the former Soviet Union and in other authoritarian regimes.

Gay activists in the mid-20th century certainly viewed the homosexuality diagnosis as an abuse of psychiatric authority and there are activists in the LGBT community who view the GID diagnoses in the same way. Given their potential for abuse, some have called for eradicating psychiatric diagnoses altogether. Such a move is highly unlikely and, in any event, doing so is likely to increase rather than diminish human suffering. Some have sought to discredit psychiatric diagnoses, regardless of their clinical utility, because all diagnoses are subjective and argue that psychiatric nosology is at best a “soft science” and, at worst, not a science at all. Yet the criticism of “subjectivity” can apply to even the “hardest” of sciences, as when the International Astronomical Union recently decided, by a membership vote, that Pluto is no longer a planet (Vedantam, 2006).

Subjective considerations were not entirely lost on the architect of the current DSM diagnostic system, Robert Spitzer (1981), who struggled with similar questions decades ago:

The concept of disorder is man-made. Over the course of time, all cultures have evolved concepts of illness or disease in order to identify certain conditions that, because of their negative consequences, implicitly have a call to action to a special group of caretakers (in our society, the health professions to provide treatment), to the person with the condition (to assume the sick or patient role), and to society (to provide a means for delivery of health care and in some instances to exempt the sick individual from certain responsibilities). The advantage of identifying such conditions is that it makes it easier for individuals with those conditions to receive care that may be helpful to them. When the reasons for identifying certain conditions as mental or physical disorders are understood, it will be apparent that the question, “Is condition A (whether it be homosexuality, schizophrenia, left-handedness, or illiteracy) a disorder?” is more precisely stated as, “Is it useful to conceptualize condition A as a disorder?” or, “What are the consequences (to society, the individual with the condition, and the health professions) of conceptualizing condition A as a disorder?” (p. 211)

Spitzer, charged with answering the question of whether homosexuality should be considered a psychiatric diagnosis, came up with a unique formulation: psychiatric disorders are characterized by dysfunction and distress. Prior to that time, psychiatrists had no such formulation nor is it clear how much interest they had in the question of how to define what is and what is not a disorder. This is because both the DSM-I and -II represented an accretion of psychosocial problems brought into psychiatric practice. Diagnoses were there because they represented phenomena that psychiatrists treated and what psychiatrists treated was based on the field’s origins in medicine and penology. Spitzer sought to create a more unified approach, one that would diminish the influence of meta-psychological psychoanalytic formulations on psychiatric diagnosis and link the DSM to contemporary scientific research models and to the empirically based practices of other medical specialties. Further, and to his credit, he also included so called V-Codes, acknowledging that not all problems presented to psychiatrists rose to the level of a psychiatric diagnosis.

In recognition of the fact that “disorders” occur in a psychosocial matrix, the Introduction of the DSM-III (APA, 1980) notes:

In DSM-III each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symp-

tom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society. (When the disturbance is *limited* to a conflict between an individual and society, this may represent social deviance, which may or may not be commendable, but is not by itself a mental disorder.) (p. 6)

Psychiatric illnesses, like “social deviance,” often create conflicts between individuals and society. Consequently, both the psychiatrically ill and minority groups are subject to stigma. As noted in the WPATH *Standards of Care* (2001), “The designation of gender identity disorders as mental disorders is not a license for stigmatization, or for the deprivation of gender patients’ civil rights” (p. 6). Stigmatization of individuals with psychiatric disorders is a social problem with which APA is quite familiar. Organized psychiatry and other mental health professionals have spent decades trying to reduce the stigma of psychiatric illness in order to increase access to care and to encourage people to avail themselves of mental health services. Mental health professions are themselves stigmatized because of their association with the conditions affecting the populations they treat.

It is, therefore, understandable that many transgender individuals, already stigmatized for their expressions of gender variance, would wish to avoid the added burden of being labeled as having a “mental disorder.” This is especially true for members of the trans community who are not anatomically dysphoric and who neither seek nor desire medical or surgical intervention to change their bodies. Further, many in the trans community who do seek medical intervention prefer being diagnosed with a “medical condition,” rather than a psychiatric disorder. Yet most psychiatrists today would argue that psychiatric disorders are medical conditions. One unintended consequence of belaboring distinctions between medicine and psychiatry, and this is a wider social problem faced by transgender and cisgender people alike, is the perpetuation of existing stigma and prejudices against the psychiatrically ill.

If the parallels between homosexuality and gender variance are absolute, then social resistance to transgender civil rights and transphobia in general are byproducts of the psychiatric diagnoses and resultant stigma. In retrospect, the medical perpetuation of stigma was clear in the case of homosexuality. History has vindicated the efforts of those early gay activists who believed that removing that diagnosis from the DSM would reduce their social stigma and elevate their social status. If that is also true of gender variance, then removing the GID diagnoses from DSM could accelerate trans social acceptance and tolerance.

Today’s trans activism, however, is taking place in a much different climate than the environment in which gay activists

found themselves four decades ago. In fact, many of the changes in gender beliefs wrought by the gay rights movement have altered social discourse and society’s values in ways that have created opportunities for the trans community as well. In contrast to the obstructive role the diagnosis of homosexuality played in gay people’s lives, and despite the persistence of trans diagnostic categories in both DSM and the ICD-10, the social acceptance of transgenderism and articulation of transgender rights has increasingly unfolded in both the U.S. and abroad (see Green, 2009b; NGLTF, 2007, 2008; Yogyakarta Principles, 2007). Growing recognition and increased acceptance to date should not be interpreted as a rationalization for retention of the diagnosis but only as a statement of fact. Further, it is entirely possible that the lagging social acceptance of gender variance will catch up with the more advanced social normalization of homosexuality. For example, gay marriage, once unimaginable, is now the law of the land in many places. It is not unthinkable that, in the future, gender variant people transitioning from one sex to another might be treated by medical specialists who, like obstetricians, use medical and surgical interventions to facilitate what society considers to be a normal life event.

How far is society from such a normalizing outcome? Forty years ago, it seemed unlikely that the average person would have accepted the idea of gay marriage. Today, polls show a majority of Americans support marriage equality (Langer, 2009). In the United Kingdom, individuals who have undergone reassignment can marry with the legal status of the post-operative sex (Green, 2009b). The situation is much grimmer in the U.S. where postoperative marriages by trans individuals have been annulled by court decree (Currah et al., 2009). So although the psychosocial context for evaluating gender variance is rapidly changing, today there is a practical concern that it might be difficult to convince most people that transition from one sex to another is as “normal” as childbirth. That day may come, and in some places it has already arrived, most notably in those communities and schools that are increasingly supportive of allowing young gender variant children to adopt the gender role they feel is consistent with their gender identity (Kennedy, 2008; Rosin, 2008; Spiegel, 2008a, 2008b).⁸⁶

What role should APA and the DSM play in changing society’s attitudes toward transgenderism? Bayer (1981), in his analysis of the 1973 APA decision, believed “the psychiatric mainstream must ultimately affirm the standards of health and disease of the society within which it works. It cannot hold to discordant views regarding the normal and abnormal, the desirable and undesirable, and continue to perform its socially sanctioned function” (p. 194). If that is true, psychiatry cannot

⁸⁶ Silverstein (2009) makes a similar argument that changing sexual mores propelled by the growth of and exposure to Internet pornography will render obsolete contemporary cultural notions of paraphilias.

take a leadership role in changing social attitudes but must instead merely follow or mirror society's values.

Bayer's conclusions, however, proved to be in error,⁸⁷ although it took the passage of a generation before society felt the deeper effects of APA decision to remove homosexuality from the DSM. After the 1973 APA decision denied religious, political, military, and educational institutions a medical rationalization for discrimination, the debates surrounding homosexuality shifted from the medical and scientific arenas to the social, political, and moral forums where they properly belonged. Consequently, by the mid-1990s, American policy makers at the highest levels of national and state government were engaged in heated debates regarding marriage equality and the rights of gay people to serve in the military. It is entirely possible that removing GID from the DSM would do the same for transgender rights. One should not underestimate the stigma-reducing effect if being trans is no longer considered a psychiatric disorder.

Yet, as a practical matter in the here and now, and as Meyer-Bahlburg (2009) details in a related review, removal could have other consequences, specifically the loss of medical and legal justifications for medical treatments facilitating transition for anatomically dysphoric trans individuals.

Last, but not least, this review has not taken up the issues surrounding the treatment and place of GIDC in the DSM. While there is a growing acceptance of treating adults who present for transition, the meaning and approach to gender variance in children and adolescents is more controversial. It is beyond the scope of this paper to review those issues (see Bartlett, Vasey, & Bukowski, 2000; Cohen-Kettenis & Pfäfflin, 2009; Corbett 1996, 1998; Ehrbar, Witty, Ehrbar, & Bockting, 2008; Hill et al., 2007; Isay, 1997; Kennedy, 2008; Korte et al., 2008; Menvielle, Tuerk, & Perrin, 2005; Möller, Schreier, Li, & Romer, 2009; Richardson, 1996, 1999; Wallien & Cohen-Kettenis, 2008; Zucker, 2008a, 2008b, 2009) but it is worth highlighting some of them.

Are all presentations of gender variance in children non-pathological? Is the psychological distress associated with gender incongruence in children the result of internal processes or unaccepting social responses? Is it possible to clinically distinguish a pathological GIDC from normative gender atypical behavior of children who may or may not grow up to be gay or transgender? Given that most cases of childhood gender incongruence do not persist into adulthood, are there subtypes of GIDC? If so, can they be distinguished from each other? Does empirical research support the claim that clinical interventions with gender variant children can prevent persistence of gender incongruence into adolescence

and adulthood? If so, is it advisable or ethical to treat children in order to prevent adult transsexualism? To whom does it matter if a child grows up either gay or transgender? Does the current state of empirical research support treating prepubescent children with hormone blockers to prevent the onset of puberty and the facilitation of transition in later life? What of the gender variant child whose social environment both accepts and encourages an early transition but may be unaware that the child, unwilling to disappoint, has had a change of heart (P. T. Cohen-Kettenis, personal communication)? Who should be designated as the best advocates for gender variant children? Parents? Teachers? Government agencies? Mental health professionals? Adult transgender activists? Queer theorists? These and many other questions not easily answered and all will require further study as well as thoughtful analysis and discussion.

Recommendations

How should APA proceed? Physicians need to take to heart the dictum "first do no harm." This guides many clinical encounters in which physicians and patients must make treatment choices, all of which are potentially fraught with harm. In those cases, the best approach is to make choices that maximize benefits and minimize harm (or side effects). At this moment in time, I believe the less harmful choice would be retaining and modifying the adolescent and adult GID diagnostic criteria to make them more narrowly inclusive of individuals who are distressed about the dissonance between their anatomical and psychological gender.

Given the potential for stigma, why retain the diagnosis at all? As previously noted, unlike the case of homosexuality in the 1970s, the expansion of trans rights has not been entirely obstructed by the DSM diagnoses, although it is entirely possible that the DSM diagnoses may have played (and are still playing) an inhibitory role delaying the pace of change. Yet, despite the GID diagnoses being on the books, the acceleration of trans legal protections in the last decade has been rapid (NGLTF, 2007). While retaining the diagnoses, even with modification, can undoubtedly contribute to perpetuating stigma (in a manner similar to being diagnosed with major depression or bipolar disorder can be stigmatizing), such an outcome would constitute a lesser harm to anatomically dysphoric members of the trans community than the denial of access to medical and surgical care likely to ensue following removal from the DSM. However, narrowing current DSM-IV-TR diagnostic criteria to exclude trans individuals who are not anatomically dysphoric nor distressed would also go a long way in reducing the stigma experienced by a sector of the trans community.

The DSM-V Workgroup on Sexual and Gender Identity Disorders, the DSM-V Task Force, and the APA can take

⁸⁷ APA has also played a significant leadership role in past decades in reducing social stigma associated with public conversations about psychiatric illnesses like depression and anxiety, in normalizing the use of psychotropic medications, and in the growing cultural acceptance of "talk therapies."

steps to reduce the potential harm of stigmatization and improve access to needed medical care.

Recommendations to the DSM-V Workgroup on Sexual and Gender Identity Disorders and the DSM-V Task Force include:

- Modify the language of DSM-V GID diagnoses so they are less stigmatizing of gender variance in general;
- Separate gender diagnoses from the sexual dysfunctions and paraphilias;
- Separate any childhood diagnosis in the DSM-V from adult transsexualism to avoid existing nosologic confusion between GID categories in adults and children;
- Narrow the DSM adolescent and adult GID criteria so that the diagnosis only applies to individuals who are anatomically dysphoric;
- Rather than wait for a DSM-VI revision, periodically revisit the question of including gender diagnoses as societal attitudes toward gender variance continue to evolve.

Recommendations to the APA:

- Reaffirm APA's commitment to opposing the stigma associated with psychiatric disorders and accessing mental health services;
- Charge either an existing APA committee, council or component or a new one with official responsibility for transgender mental health issues and advocacy;
- Review the WPATH (2001) *Standards of Care*:
 - Either endorse them as the American Medical Association has done; or
 - Develop and publish APA's own practice guidelines for whatever DSM gender diagnoses are modified and retained in a manner consistent with established clinical practices, input from patients, and the empirical data base;
- Support and encourage research into further study of the benefits and harms of current GIDC treatment approaches;
- Issue position statements, lobby and file amicus briefs in support of trans civil rights and non-discrimination and affirm that gender variance does not imply any impairment in an individual's judgment or competence; and
- Proactively state support, lobby and when necessary file amicus briefs to increase public and private health insurance coverage for medically necessary treatment of transgender individuals and oppose categorical exclusions of coverage for treatments prescribed by a physician.

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